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THE SAINT LOUIS

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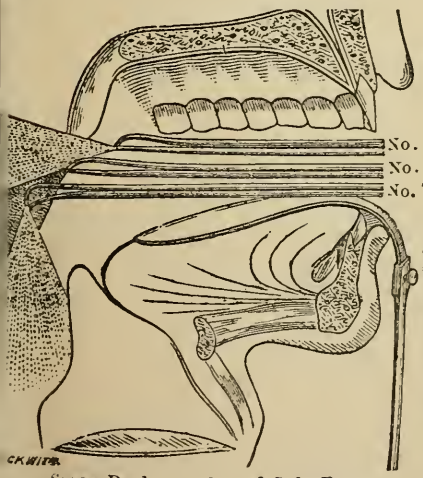

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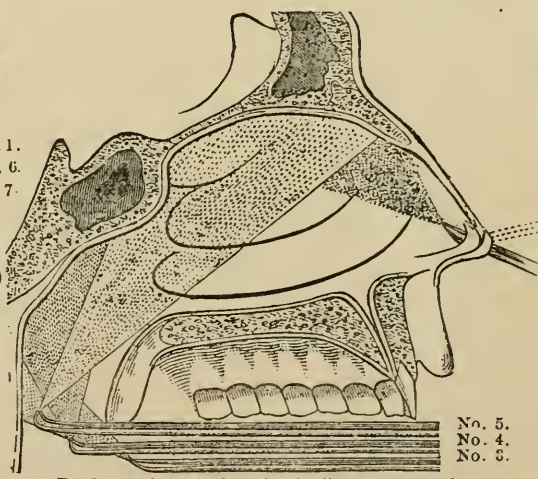

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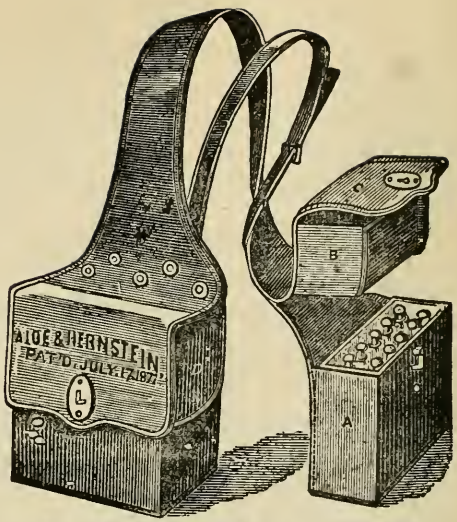

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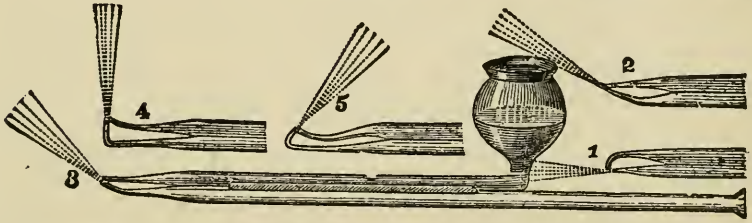

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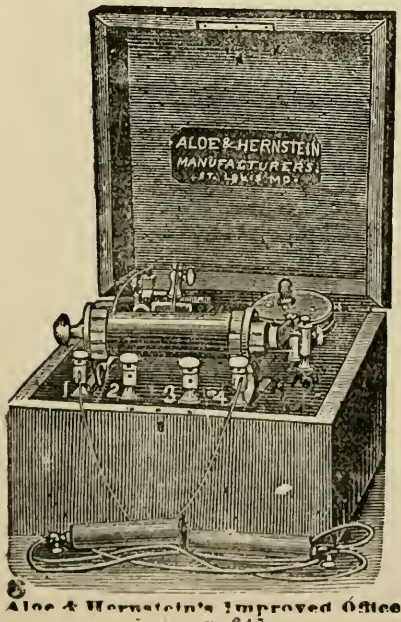

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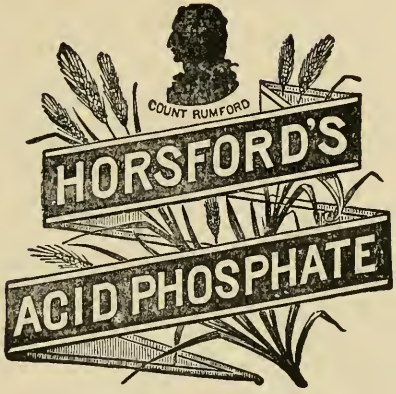

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Let the patient put eight or ten drops of Acid Phosphate into half a glass of cold water, and take a sip of it, say a few minutes before rising or whenever the sickness or nausea is coming on.

It is equally effective in hot water, or tea without milk or sugar, and to some may thus be more palatable. In such cases use the same dilution as above. Some constitutions may need a stronger dilution, which fact, experience alone can decide.

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Vol. XLIV. JUNE, 1883. No. 6.

Original Contributions.

Article LVII.

Report of a Case of Battey's Operation.* By N. A. Drake, M. D., of Kansas City, Mo.

In December, 1881, I was consulted by an intelligent colored girl, 21 years of age, for painful menstruation.

She said she always suffered terribly during her monthly periods, so much so that she was obliged to be in bed half or two thirds of her time. I gave her a superficial examination, and as she was not suffering then, asked her to see me again when menstruating.

Several days after she sent for me. I found her on the floor writhing in pain, which appeared to be spasmodic, simulating labor pains. She had not yet commenced to flow. I proposed to give her morphia hypodermically, but she said she could not take morphia, it made her so sick. However, I gave one-quarter grain, guarded by one one-hundred and twentieth grain atropia, as per Barthelow. When I inserted the needle she went off into a convulsion. From appearance would call it hystero-epileptic. This was followed by a State of quietness that lasted for several minutes. She came out of it with one of those paroxysms of pain.

I was informed she would have such convulsions many times a day during menstruation; and when she was well she would have them on the least excitement, mattered not where she was, she would fall down in a fit.

I used all the external applications usual in these cases, to cause her to menstruate, viz.: hot hip baths, foot baths, heat locally, hot vaginal injections, etc., etc.

The nausea did follow the use of morphia. It seemed to me I never saw more obstinate nausea; the stomach would retain nothing for some time; but after many repeated doses of cerium she got better. This state of things continued until the menstrual flux became established. The stomach, however, remained

* Read before the Jackson County Medical Society, January, 1883.

very irritable, and the pain continued, although not so severe.

I think I gave her more relief by small doses of atrophine hypodermically than from anything else.

When she got around from this she came to my office for an examination.

I found her, for her class, a very intelligent girl. Had lived for several years in one of our best families in the city.

Her history, as related by herself, is about as follows: She commenced menstruating when about sixteen years of age, and it was always painful. More at times than others.

Had had these fits since she commenced to menstruate; has falling of the womb, and had worn a pessary for nearly a year. The stomach had always troubled her. Had had all the diseases imaginable, to let her tell it. Had been catheterized for nearly three years, nearly all the time. Sometimes just before menstruating could pass water for a few days. Was paralysed for several months a couple of years previous. Could not walk for some time.

On examination I found a closed bar pessary in the vagina, and it was nicely adjusted. Removed it, and after a thorough investigation, could find nothing wrong only the uterine displacement and a prolapsed ovary. Some cystitis, as a matter of course, but from analysis of urine could find no disease of kidneys.

After considering some time, I put her upon a constitutional treatment, which amounted to but little, as her stomach would not tolerate anything any length of time. Gave bromides, and they were retained till her fits were not quite as often. The lady with whom she lived catheterized her every day, or every other day. She had learned, if she went without drinking, she could go three or four days without having catheter passed.

You will at once discover that the hysterical element in the girl's nature largely predominated, although I saw her in some of her convulsions when they had more the appearance of epilepsy.

Her next menstrual period was worse, if possible than the previous. I used atropia in larger doses, and finally by combining a little morphia with it, succeeded in controling pain to a great extent.

It is not necessary for me to follow the case from month to

month, as each menstrual period was, practically, a repetition of the other.

I became convinced that medical treatment would do her but little good, and after considering the case from every standpoint I advised the removal of the ovaries, or marriage, expecting pregnancy might be beneficial.

The latter course she declined, and after a short time to consider it, she accepted the former, after I had stated to her plainly the dangers of the operation, and the chances of a cure if she should get well of the operation. She was anxious to take the chances, as she could expect no permanent effect from medical treatment after having apparently tried and exhausted nearly all known therapeutic measures.

Pof. Hegor, of Germany, probably was the first surgeon to remove the ovaries for diseased conditions, July 27, 1872.

We read of the amorous Lydian Kings having their concubines spayed, so they might preserve their beauty, etc., etc., and to satisfy their insatiable lust; and we also read of a Hungarian *sow gelder* spaying his own amorous daughter.

But, as stated above. Prof. Hegor was probably the first man to do the operation legitimately, and it was a few days later, August 2, 1872, done by Lawson Tate, of England. Prof. H. first did the operation to arrest the growth of fibroid tumors of the uterus. His reasons for it were evident. It had been observed in woman with fibroid tumors that after the change of life the tumors ceased to grow, and in many became smaller. He conceived in this that the life of the fibroid tumor was the blood supplied by the monthly congestion. Hence, if he would remove the ovaries he would produce premature change of life and thus stop the growth of the tumor. Upon these hypothesis he acted, and he reports quite a number of cases in proof of the correctness of his theory. And also the operation being far less dangerous than the eneucleation of the tumor or the extirpation of the womb.

Other operators have followed him, and all corroborate the correctness of his views.

But to Dr. Battey, of our own country, are we indebted for the operation for the cure of dysmenorrhœa, epilepsy and mental diseases bordering on insanity, after all other means and remedies have failed.

(Dr. Battey operated in August, 1872, a few days later than

Dr. Tate; but he, Battey, published his cases to the world, while Dr. Hegor and Tate did not publish theirs. Hence Dr. B.'s claim to priority.)

Probably in no country has gynæcology made so rapid strides in the past twenty-five years as in America.

The profession at home concede to Dr. Battey, of Romer, Ga., a front rank for this operation which rightly goes by his name.

In Europe it is not an acknowledged operation for dysmenorrhœa, and we have some surgeons among us who are yet unwilling to accept any great operation unless it is brought across the water. I have heard Emmet's operation condemned, and yet for all of that it has taken its place as an acknowledged operation, even among English surgeons, who are not willing to accept originality from the United States. And Battey's operation is forcing its way to an acknowledged place in the same way.

Dr. Goodell says, and his authority is unquestioned: "The operation of spaying is yet in its infancy, and time is needed to develop its resources. But I can not help feeling that in carefully selected cases, it will prove the sole means for curing many mental and physical disorders of menstrual life, which have hitherto baffled our science, and are a standing opprobrium to our profession."

What I hoped and expected to gain by the operation: Cessation of menstruation directly. Although tabulated cases by Emmet and Goodell give a small per cent of menstruation so-called, after operation; but I can not look upon it other than a flux, and thus to relieve the terrible monthly pains, and through this to cure the hystero-epileptic convulsions.

The mortality from the operation is not greater than from other capital operations. Agnew, in his work, gives a general summary of 171 cases, 139 recoveries and 32 deaths, or 18.72 per cent. Of the 171, 144 were by laparotomy, of which 117 recovered and 27 died, or 18.75 per cent. 27 were by elytrotomy, with 22 recoveries and 5 deaths, or 18.57 per cent.

You see, by this, the operation through the vagina gives the smaller death rates. But remembering the experience of Goodell, where he was obliged to do abdominal section after having made the incision in the vagina and found the ovaries beyond his reach, being bound down by adhesions, I concluded

it would be advisable to go through the abdominal walls. In this I had the concurrence of Drs. Cathcart & Mitchell, after taking into consideration all the chances of their being an adhesive inflammation.

After quite a number of delays, owing to her irregularity in menstruating and the irritable stomach, on April 29, 1882, assisted by Drs. Cathcart and Mitchell, and Mr. Burgett, medical student, I removed her ovaries by abdominal section.

I will not take your time in describing in detail this operation, suffice it to say: the ovaries were easily reached through a three inch incision; ligated them with carbolized silk ligature; closed the wound with silk worm gut ligature, and dressed with cabolic cerate and absorbent cotton, with flannel binding around the body. Used carbolic acid as an antiseptic. All sponges, instruments, ligatures and water used were all carbolized. Used ether as anæsthetic. She rallied well from the operation. Got union by first intention, and she got along for three weeks without an unfavorable symptom.

About this time she began to sit up, and circumstances over which we had no control compelled us to move her to another house, the sanitary surroundings of which were not the best. She sat up part of the time, and everything appeared to be swimming along nicely, when she took a violent chill. I expected to find some peritoneal trouble, or some inflammation caused by the operation, but could detect nothing of the kind.

Gave quinine in anti-periodic doses, but our old enemy, the stomach, refused to tolerate it. The chills returned every 24 hours, and the fever was constant. I soon became convinced I had a veritable case of malarial fever. I resorted to quinine hypodermically, but it was difficult to get enough into the system in this way to do any good without causing abscesses.

Finally I resorted to suppositories of quinine. This did well for a week or ten days, when the rectum rebelled.

But I rung the changes as best I could on these three modes, when, after a struggle of several weeks she gradually began to improve.

On trying to get out of bed she claimed she had no use of her right leg, and surely there was a certain degree of paralysis. I insisted on her getting around, had a pair of crutches made for her, and fairly forced her to use them. She improved rapidly, and I had ceased visiting her but occasionally, when I was

summoned again, and found her suffering from dysentary. This lasted for a couple of weeks, when it gradually subsided, but left her with external hæmorrhoids. These I laid open and pressed out the clot of blood, and I heard but little of them after that. From that time until the present, January, 1883, her improvement has been uninterrupted.

She is now capable of taking care of herself. Somewhat lame yet, but see no reason why she should not entirely recover. The bladder trouble still remains, but not so obstinate.

I am treating it with faradism with an insulated electrode in the urethra and bladder, and the positive pole in the inguinal region. She will pass her water for two or three days after each seance.

Results. She has had, several times, a slight bloody discharge, no pain with it. Hence, the dysmenorrhœa has never returned. Occasionally, when she gets very nervous, she will have a convulsion. But she does not have one now where she used to have fifty. All in all I consider the results highly gratifying, although we encountered obsticles we never dreamed of. But I believe the amount of good accomplished is worth to her all she has undergone, and she so expresses herself.

I am convinced she will continue to improve, and hope soon to get her in condition to urinate all the time, herself. But so many surprises have occured in the case that I shall not be surprised at anything that may yet occur. The case has been an interesting one all the way through, to me, and is one that puts a man to his wits' end, often, to meet the emergency.

Thinking that the many interesting points might elicit a discussion that would be interesting and beneficial is my excuse for reporting it.

At this date, April 11, 1883, the woman is comparatively well. She urinates nearly all the time herself. I have about ceased to use electricity. She comes to my office occasionally yet for it, more to relieve the pain in her lame leg, than anything else.

Sometimes she will have a slight uterine discharge of blood. Once quite freely while suffering from a severe cold.

Since preparing the above paper I have read what Lawson Tait has published in the *British Medical Journal.*

In that he contends that we are all mistaken about the organs that control menstruation.

We have all been taught that the ovaries presided over this function, but he claims the fallopian tubes are the organs that control menstruation, and proves it, to his satisfaction, by removing the tubes with the ovaries, and has no flux *at all* after it.

This would seem to be evidence conclusive, but we must remember that the greater number where the ovaries, only, are removed, have no discharge after it. We all admire the success and boldness of Tait, but I must confess that I am not yet far enough progressed—excuse the term—to accept his theory of menstruation.

Somehow our native gynæcologists do not have the wonderful success of Tait. In his last thirty-five operations for the removal of ovaries and tubes he has not had a single death.

We feel proud of our eminent Battey, Thomas, Bozeman, and a score of other American operators, but none have arrived to his point of excellence.

Circumstances, of course, must be different. We live in progressive days, and we have no fears that our Yankee nation will be left very far behind.

Article LVIII.

Resection of the Right Superior Maxilla, the Pterygoid Process of the Sphenoid, of a Portion of the Body of the Sphenoid, and of the Vertical Plate of the Palate Bone. By C. R. S. Curtis, M. D., Surgeon to St. Mary's Hospital, Quincy, Ill. [Reported for the Journal.] By M. Rooney, A. M., M. D., Professor of Principles and Practice of Surgery in the Quincy College of Medicine.

November 27, 1871. Ten days ago Andrew Persons presented himself at St. Mary's Hospital for examination and treatment.

A. P., æt twenty-five, sanguine temperament, weight one hundred and sixty, height five feet and eight inchse, of good muscular development, a native of Sweden, has no evident cachexia, intelligent for his condition in life, a laborer. Upon examination there was found to be a tumor of the right superior maxilla, implicating the adjacent soft parts. The tumor was quite extensive, beginning anteriorly at the symphesis and extending to the zygomatic surface of the maxilla, involving the alveolar process of the maxillary bone, and the soft parts, to a considerable extent, back to the tuberosity of the maxilla, and filling the antrum highmorianum. How much more extensively the surrounding tissues were involved was not then exactly and definitely ascertained, though it was surmised that the morbid process had advanced to no slight degree in the neighboring regions.

Were it not for the presence of the tumor, the subject was apparently healthy, having a florid freckled complexion, sandy hair and blue eyes. He had always enjoyed excellent health, never has been tainted with venereal poison, nor, to his knowledge, have his ancestors transmitted to him any disease. He emigrated to this country three years ago. Has lived in several of the Western States, and, for a few months past, has lived near Macon City, Mo. The subject can assign no cause as to the origin of the tumor. About three months ago he was annoyed with pain and soreness of the right sup. maxilla. The molar

teeth in that jaw having become loose were extracted, which operation was followed by considerable hæmorrhage.

From the time at which the teeth were drawn the tumor has rapidly increased in size, and even since the subject's entrance into the hospital, ten days ago, the augmentation is evident.

That portion of the tumor involving the alveolar process seems to be somewhat movable, which motion is due, probably, to the increased vascularity and interstitial absorption of the inorganic elements of the bone.

The patient having been kept for several days on low diet, and the bowels being regular, no further constitutional treatment was premised.

After free consultation with many members of the profession, the patient was operated upon, November 27, 1871.

In the operation Dr. Curtis was assisted by some of the medical men of Quincy, Dr. Robbins, President of the Adams County Medical Society, being present.

Six ounces of whisky were first given to the patient; he was then placed upon the operating table, and chloroform was administered. The right superior middle incisor was extracted, then an incision was made from the right angle of the mouth to the center of the right zygomatic arch. This incision was then extended over the lower part of the malar bone and below the orbit toward the nose, about to the infra orbital foramen.

The flaps were then rapidly dissected up, exposing the tumor, masseter muscle (part of which was cut through), the ramus of the inferior maxilla, the malar bone and superior maxilla. The cutting forceps were now applied to the alveolar process, dividing at the point from which the mediam incisor had been extracted, cutting through the roof of the mouth along the corner to the junction of the right palatine bone. (Before this latter operation the soft parts within the mouth were incised in the usual manner.) The forceps were then removed, the lower portion of the malar bone was separated, with the saw, from its upper, forceps were introduced, cutting through the maxilla in a line just below the orbit, from the nasal cavity to the pterygoid process, through the vertical plate of the palatine bone. The tumor was then seized with a strong pair of forceps and was easily depressed, when the remaining attachments of the soft tissues were severed with the scalpel, and the tumor was removed nearly *en masse*.

Some points of diseased bone at the base of the pterygoid process, and of the body of the sphenoid remained, which were cut away with the forceps and a considerable mass of unhealthy looking tissue was removed from the cheek over the site of the malar bone.

The incisions were followed by copious gushes of blood. The wound was sponged with alum water, and digital pressure was, temporarily, applied to the cut facial artery, and a little later to the internal maxillary. The hemorrhage having been diminished, no further attention, for the time, was paid to it. Some suspicious surfaces were cauterized with the actual cautery. About fifteen ligatures were applied to the facial and internal maxillary and their branches and other branches of the external carotid. Solution of persulphate iron was freely made use of after the operation.

The time consumed in the operation from the first incision to the removal of the tumor was but ten minutes. The wound was filled with lint saturated with alum water. The flaps were brought together and kept in position with harelip pins and the interrupted suture. The parts were supported with adhesive plaster and bandages, and dressed with carbolized cold water dressing.

The patient lost about three pints of blood, but bore the operation well. After the completion of the operation Dr. Curtis gave the patient half a grain of morphia by the hypodermic syringe, and ordered whisky to be given to him in half ounce doses every hour. The patient was left at 2 P. M.; saw him again at 8 P. M.; he was then comfortable, reaction coming on; had slept some; ordered whisky to be given until reaction be complete; also carbolized water dressing to be continued.

Upon examing the entirety of the morbid material removed it was found to have involved the alveolar and palatine processes and pterygoid border of the maxilla, the vertical plate of the palate, the pterygoid process of the sphenoid down to the base, and including a small portion of the body of that bone. All were blended into a fungus mass of the cellular consistence, spongy and vascular, with but little bony inorganic matter remaining.

November —, 9 A. M.—Found the patient suffering from retention of urine. Drew off three pints of urine, when the patient felt much relieved. Complains of soreness of face and

throat. Pulse, 100 full and soft. Reaction complete. Ordered ℞. Olei Ricini ℥ i, to be given immediately. Continued whisky in small quantities, also broth and milk. 7 P. M. Oil has not operated, Pulse 96; complains of pain in the throat, considerable swelling of face; no hæmorrhage, has passed urine in small quantities three times. Condition satisfactory. Ordered Olei Ricini ℥ ii; to continue nurishment and cold applications.

Thursday, November. 9. A. M.—Patient quite comfortable; rested well last night. Pulse 90; swelling of the face about the same. Bowels moved four times since last visit. Patient is troubled occasionally with hacking cough, expectorating mucous sputa. Wound looks healthy, beginning to have some purulent discharge. But little pain, and patient is quite cheerful. Takes fluid nourishment quite freely. Ordered beef broth and milk and

℞. Vine antimonialis.. .....℥ij.
Spiritus aetheris nitrici.....℥ i.
Aquae distillatæ.....℥ iij.
Morphiæ sulphatis.....grs. iv.
M. S. Coct. min. om. hora sumendum est.

9. P. M. Has slept several hours to-day; says he feels easy; considerable swelling of face; pulse 96, wound suppurating; continue treatment.

December 1.—Patient doing well; pulse 80, swelling of face diminishing; suppuration freely established. Removed lint from wound and thoroughly washed it out with ℞. Ferri per Sulp. Solutions, Acidi Carbolica, āā℥ij; Aquae Dest. Oij. External wound healing at several points by first intention; other points are suppurating. Patient feels more comfortable since the lint has been removed from the wound. Has sat up every day whilst his bed was being made; seems to have considerable strength; tongue clean, no secondary hæmorrhage has yet occurred; slept well last night. Suspend medicine and continue beef tea, egg nog and milk. Mouth and inner wound to be washed frequently with carbolized water, continue carbolized water as external dressing.

January 1, 1872. Patient has improved steadily. Reparation has proceeded well, and considerable osseous reproduction has taken place. No evidence of a return of the disease is manifested, and the patient leaves the hospital cured.

Translations.

Article LIX.

FROM THE FRENCH.

Excerpts from Late French Journals. [Translated for the Journal.] By S. Pollak, M. D., of St. Louis.

Cataleptic Condition of Muscles.—Brown Sequard says something similar to catalepsy can be produced in muscles, and in muscles only. It is difficult to assume that any part of the nervous system is the cause of it, for the phenomenon can be produced two hours after death, the destruction of the spinal cord does not modify it, it does even increase it. This cataleptic state is so clearly manifest, that there can be no doubt about it. Any member will maintain a position given in a state of rigidity; and this is not the cadaveric regidity, for that never changes.

Convulsive movements are often observed after death from cholera or yellow fever. Brown Sequard cites a case which he has witnessed. A man who died of cholera several hours since, brought his two hands together and raised both arms high up, and retained them there for some time. Convulsive movements of amputated limbs are frequently seen.

There is no doubt that the phenomenon has its seat in the periphery and not in the nerve centers. These facts lead to conclusions, that there exists in the muscles a condition strongly analogous to that designated as a cataleptic state and that the contractile tissues can possess a certain power of action more or less resembling that which is through the influence of the nervous system. The contractile system is therefore more allied to the nervous system than hitherto supposed.—[*Gaz. des Hôpitaux.*

Treatment of Warts.—With an ordinary pin transfix the wart at its base, but the point of the pin must not project, and the pin must nowhere touch the skin, which must be protected by some intervening substance—a piece of paper or wool. Heat the *head* of the pin with the light of a candle, and you will

literally cook the warty substance. If the heat should be too great, withdraw for a moment the light. In about ten or fifteen minutes the cooking of the wart will be complete. It will turn white and crevice in every direction and will be surrounded with a red halo. The whole wart can then be lifted out with the pin. It will leave a circular superficial cicatrix.—[*Journal de Med.*

Electrolysis is quicker, less painful and more efficient.—S. P.

GLYCOSURIA IN MAMMARY ABSCESSES OF NURSING WOMAN.—It was formerly held that glycosuria is present with all pregnant and nursing women; but this is only true of women in the puerperal state who happen to lose suddenly their milk, which according to Verneuil, is always the case with those who suffer from mammary abscess. Dr. Vasher makes very interesting experiments which demonstrate that, at the advent of a mammary abscess, nursing is generally discontinued, yet the flow of lactal fluid to the breast is the same, an absorption of milk sugar takes place, which is again excreted with the urine. But this is really not *glycose* which is found in the urine, it is *lactose*. That this lactosury has its origin in the resorption of breast milk, is proven by its sudden disappearance in milking animals, from whom he amputated the lactal glands.

Glycosury whenever found, is of very serious import, and no surgical operation should be performed on breasts from which the milk has not entirely disappeared. Verneuil thinks that diffuse inflammation, suppuration and even sphacelus is apt to follow all surgical interference at that epoch.—[*France Medicale.*

SPLENIC COUGH, HEPATIC COUGH.—Prof. Trastour, of Nantes, publishes an interesting study in the *Revue de Medicine*, Jan., 1883, on cough of splenic or hepatic origin. The reflex action of abdominal organs upon the heart, the lungs and the brain are well known; also cardiac troubles of stomachic, hepatic or intestinal origin. Gastric coughs have been described by writers on chlorosis, hysteria or dyspepsia. A practiced ear will never mistake the nervous, spasmodic character of a spleno-hepatic cough, which is usually without expectoration, hoarse more or less frequent and sharp. It comes, as a rule, after eating, or on palpation or percussion of spleen or liver. If accompanied with fever, this cough is most annoying during the chill. In all such

cases, the spleen or liver have been found enlarged, either from paludal influences or dyspeptic troubles.

This cough has generally nothing disquieting about it, but if joined with palor, loss of flesh, anorexy, general weakness, shortness of breath, and a cachectic appearance, if found in a valetudinarian, or in age of adolescence, then it assumes a grave character. Pulmonary disease is *suspected*, but a critical examination of the thoracic organs *finds their integrity unimpaired*, and the converse is the case with the spleen and liver, which are hypertrophied and painful to the touch. The prognosis is more favorable and generally amenable to treatment—chiefly to feruginous tonics.

Prof. Trastour concludes:

1. We must clinically admit a splenic cough, a hepatic cough as well as a gastric cough.

2. We must in the presence of concomitant cachectic symptoms assure ourselves of the integrity of the lungs and pleura, prove the condition of the liver and spleen, which, if found engorged, may with suitable treatment, terminate in entire recovery.

The cough is *not* brought about by an irritation of the pneumogastric nerve. Morel, Arloing and Franck have seen the airioles of the lungs to contract on an irritatlon of the spleen, liver, stomach and intestines; they have demonstrated by numerous experiments, that the reflex action is brought about by the *sympathetic* and not the *vagus*. The treatment of the engorged liver or spleen, consists chiefly of quinine, revulsives, and the wearing of a broad light belt around the hypochondriac region for some time after convalescence.

Article LX.

FROM THE GERMAN.

Excerpts from Late French Journals. [Translated for the Journal.] By S. Pollak, M. D., of St. Louis.

Boric Acid.—In two cases of vaginitis of little girls, the boric acid was used with prompt, good effect. In nineteen cases of *erosion* of the *portio* with moderate cervical catarrh, was bor. glycerin (10-100) used with good result; in eight others the insufflation of the dry boric acid. Absorbent cotton dipped in boric acid is much used in vulvar catarrh. Also in *ozæna* with atrophy of the mucous membrane is bor. glycerin much used. Five cases of *pharyngitis* with retro nasal catarrh were quickly relieved by insufflation of boric acid.—(*Med. Zeitung.*)

Subcutanetus Injection of Carbolic Acid.—In three cases of muscular rheumatism, ten injections were made ($\frac{2}{100}$) around the shoulder; in one hour pains subsided, after the sixth, patient was entirely free of pain and remained so.

A lady who had suffered long from ischias of the right leg, who had used massage, had the nerve stretched by Billroth, without relief. Carbolic acid was injected, 12–20 daily, later 30 a day and lastly, 40 a day and was entirely and permanently relieved. The needle must be inserted vertically, that the fluid may permiate the muscular tissue. Carboltoxæmia was never seen to occur; urine remained clear.—[*Ibid.*

A Congenital Total Absence of Both Eyes.—Dr. Peterson, of Petersburg, reports having a congenital total absence of both eyes. The child was two weeks old. The form of the lids was normal; on separating them there was no trace of an eye to be seen. The conjunctiva bulbi presented two (six-millimetre) deep depressions. The child was otherwise well formed, it developed rapidly and grew finely.—[*Ibid.*

Blinding of the Retina by the Direct Light of the Sun.—

Dr. Plehn had an opportunity of examining four cases of the above disease, after the eclipse of the sun, May 17, 1882, brought on by indirect inspection of the sun through insufficiently tinted glasses. With all four, the acuity of vision was lessened ($\frac{20}{30}$-$\frac{20}{50}$) exhibiting also a very small positive skotoma centralis. The ophthalmoscope revealed a small white spot on the macula lutea, surrounded by a red halo. This white spot is regarded as the cause of the skotoma; it is probably caused by the coagulation of the retinal albumen, by the concentrated direct rays of the sun. This hypothesis has been verified by experiments on animals, by Czerny; he blinded the retina of rabbits and examined them afterwards with the ophthalmoscope and the microscope.—[*Arch. v. Græfe's.*

ACUTE CONJUNCTIVITIS CAUSED BY ELECTRIC LIGHT.—A workman engaged in putting up Siemen's lamps, had a violent conjunctivitis which lasted eight days. It is not certain whether this inflammation was caused by the *heat* or *light* rays. All operatives complained of being dazed.—[*Opthalmic Review.*

CATARACT AND OTHER EYE TROUBLES CAUSED BY A STROKE OF LIGHTNING.—Laborin (*Græfe's Arch.*) gives an exhaustive account of an operation for cataract, performed by him, which was caused by lightning. It was that of a sea captian who stood at the helm during a thunder storm. He lay unconscious for three hours and was more or less paralyzed on coming to. The paralysis and anæsthesia of the limbs soon passed away. But cataracts developed in both eyes, quickest in that directly touched. There was also mydriasis and paralysis of accommodation. Atrophy of optic papilla finally advened.

NECROLOGICAL.—*Louis Auguste Desmarres*, the illustrious French oculist who, for nearly twelve years has withdrawn from all practical work, died at his country seat at Neuilly, August, 12, 1882. He is so well known in the United States, having been the favorite teacher of many American oculists, that a brief sketch of his life may be accepted. Desmarres was born in Everaux the 12th of Sept., 1810. His wealthy parents gave him a good education in the College of Evereux. A reverse of fortune compelled young Desmarres to earn his bread by the most menial work. At the age of twenty, he was employed in the

forrestry of the government at $240 a years; he earned something besides, by giving instructions in aquarelle painting. But his aspirations were greater. To study medicine was his object and aim. In July, 1839, he received the degree of M. D. He frequented largely the only Eye Clinic of Paris, of Dr. J. Sichel, which had attained the fame of being the greatest eye clinic extent, both for numbers of patients in attendance, and successful works.

Sichel appreciated Desmarres' assiduity and talent, and soon made him his *chéf de clinique*, a position which he held four years. In 1844 Desmarres opened a clinic of his own. He became not only the rival but the opponent of his late teacher, and an apostate of the Vienna School.

If, two hundred years hence, the question would be asked, "Who were the greatest oculists of France in the nineteenth century?" in vain would one search the annals of the French medical faculty, in vain in the library of the Academy of Medicine of France. Not even the name of the well-known and never-to-be-forgotton Desmarres will be found. But by reading the biography of the immortal A. von Græfe, his grateful pupil, there a true sketch of Desmarres will be found in the shape of a letter written by von Græfe, while in attendance in Desmarres' Clinique, as a pupil, to a friend in Berlin. It is thus:

"The clinical material is less than atSichel. There are daily about ten new, and eighty old cases. But his lectures are more interesting, and his ideas and system of teaching, new and instructive. Lately only the pupil, now the rival and opponent of Sichel. An apostate of the school of Beer, of Vienna, he takes away the esoterical condition of the eye, ignores the sensitiveness and almost sanctity of the eye, and handles it with boldness, rudeness and roughness. He considers himself the originator of topical oculistic surgery; cauterization, scarification, paracentasation are great factors in his treatment, and really with surprising results. He hoots the idea of a specific ophthalmia. He considers precautions after operations as needless. He makes ten and twelve artificial pupils a week in his policlinic, and lets patients go home immediately. An incredible number of operations are daily performed, never less than three or four. His centrifugal rent is a beautiful performance. He has great manual dexterity; eversion of lids, cathederizing the lachrymal duct, is done with a rapidity of a prestidigitator. Much can be learned from his

peculiar method of dealing with eyes, which for daring and audacity is nowhere equaled. His clinic is comfortably arranged. The pupils are required to make the diagnosis and perform all minor operations, a privilege which is enjoyed nowhere else, an advantage which can never be overestimated."

In 1863 Desmarres' clinic was the largest on the continent, and he the most busy oculist in Paris. Then all at once he retired from the active pursuit of his profession, closed his brilliant career, and installed his son into the most lucrative professional business in Paris. He married again, the second time, 28th of May, 1863, returned to his country seat at Neuilly, without ever recrossing the threshold of his clinic at Rue Hautefeuille, where he had achieved fame and greatness. (*Klin. Monatsbl. Augenheilkunde.*)

Desmarrses was an incomparable artist in ophthalmic surgergy, but he was not an oculist in the present sense and demand of the world. Diseases of accommodation and refraction were never enquired into; with the exception of the ophthalmoscope, there were no optical appliances seen at his clinic. Neither were patients exhibited, on whom operations had been performed, so that the ultimate result of many operations remained unknown. His physiology and pathology of the eye was curious and not endorsed by any of his numerous visitors. [Translator's remarks.]

EXPERIMENTAL EXAMINATION ABOUT THE DECUSSATION OF THE FIBRES OF THE OPTIC NERVE IN THE CHIASMA, BY DR. BECHTEREN, OF ST. PETERSBURG.—The assertions of Biciadecki, Mandelstam and Michel, that there is a *complete* decussation of the fibres of the optic nerve in the chiasma, are now based upon pure *anatomical* demonstrations, but are at variance with the results of *histological* experiments made by Gudden, on the chiasma of the higher vertebrata, which show *incomplete* decussation.

The decision of this important question can only be reached by *experimental physiology* as will be seen by the following:

1. After division of the optic nerve, blindness of the operated eye, dilation of the pupil, and immobility of the same on the admission of light, ensued. But when light is admitted into the sound eye, the pupil of the eye with the divided nerve, will immediately contract so that when both eyes are open, no difference in the size of the pupils will be perceived. On closing the sound eye,

instantly the pupil of the operated eye will dilate to its maximum and again become normal, when both eyes open.

2. After division of the chiasma nervorum opticum in the sagital direction, neither eye will become perfectly blind. The pupils do not dilate and they respond to light.

3. After division of one of the tracts of the optic nerve, complete blindness of neither eye ensues, but if either eye is covered or closed, difficulties of vision set in, which are always in the direction of the uninjured eye.

Hence, it results that in an animal with a divided tract of the optic nerve, an homonymous limitation of the field of vision of both eyes, exists in the opposite site of the divided nerve.

These results are decidedly in favor of an *incomplete* decussasion of the nerve fibres in the chiasma of dogs.—[*Neurol. Centralbl.*

Clinical Lecture.

Article LXI.

Extracts of Clinical Lectures Delivered by Edw. Borck, A. M., M. D., Prof. of Surgical Diseases of Children, and Clinical Surgery, College for Medical Practitioners of St. Louis, Mo. [Reported for the Journal by H. Marks, M. D., of St. Louis, Mo.]

Gentlemen: Having already studied together the various fractures and dislocations of the upper extremities that we may meet with in our daily practice, and having examined the symptoms by which they are to be recognized, and having pointed out to you, especially the points of differential diagnosis between the various injuries of bony the parts, and particularly demonstrated to you their treatment by the simplest appliances, as I am in the habit of using. Permit me to call your attention once more to the importance of bearing in mind the age of the patient and the necessity of studying the development of the bones.

Remember the cases I presented to you of the two little girls: the one with a fracture of the wrist, the other who only sustained a separation of the epiphesis. And how easy it is that by not observing correctly, one may thereby injure his patient and his reputation. Let me therefore repeat, that in separation of the epiphesis, the bony projections are not very distinct, but can be felt as two smooth tumors. That the displacement occurs above the styloid processes of the radius and ulna. That the tendons are relaxed upon both surfaces of the forearm. That the bones of the forearm are shortened, measuring from the condyles at the elbow to styloid processes. And that the styloid processes are not prominent, but are normal in their relation to the carpus; that there is absence of crepitus. But it matters not how well one would remember all these symptoms and how well one may know them by heart; if he does not educate his fingers, if he does not know the shape and size of a bone, if he is not thoroughly acquainted with all its elevations and depressions and

has not learned by practice how to distinguish them by the touch, and to recognize the same and know at once whether they are in the right or wrong place, he will be likely to make mistakes. It is not enough when you see this bone, that you can tell it is the humerus; but you should know all about it. However, for practical purposes it amounts to the same thing whether you would call this elevation the greater tuberosity, or call it a mountain; or this depressson, instead of olecranon, an abyss.

But it does not amount to the same thing if you don't know that these elevations and depressions are there, if you don't know where to find them and where they ought to be. For the surgeon it is absolutely necessary to study all parts of the body in the the normal position.

If you are called upon to see a case of fracture or dislocation, do not examine for either one, they may both be very obscure; examine for a healthy normal limb, and if then instead of normal you find some abnormality, then decide what that abnormality can be. Only by practice can you gain dexterity; if you have no one to practice upon, practice upon your own limbs.

Now let us see what we do remember of the inflammatory and exudative swelling of the shoulder joint. And as I speak to medical practitioners who have had years' of experience, and not to medical students, I may begin at once with the practical points.

The main question that comes up when a patient presents himself to us with an inflammation of any joint, is, first of all, is this inflammation intra or extra articular?

The importance of this question as well as the importance of a correct diagnosis, is obvious to every one of us. The tissues around the shoulder joint, are very numerous in comparison to other joints. And we seldom meet with a single independent muscular abscess in this region. And as the capsule of this joint is covered almost everywhere with muscles, therefore cannot this structure be the cause of an inflammation that produces a peri-articular abscess.

But we have synovial sacs between the muscles and the capsule. And it is either the one or the other of these synovial sacs, or the cellular tissue between the muscles and the capsule, that will produce a true peri-synovial abscess, if in that structure suppuration should occur.

Here we have the subdeltoid, the subacromial and the subscapular bursæ, and numerous smaller bursæs.

Inflammation of these bursæ occur very often and we meet with acute and chronic serous exudates and suppurative metastasis.

Now if a bursæ is inflamed and does not communicate with the joint, we have swelling only in a certain circumscribed region. While if there is an exudate or fluid within the cavity of the joint, the swelling will be equally distended in all directions.

Viz.: An exudation in the bursæ subdeltoida, will only elevate the deltoid muscle. An exudation in the bursæ sub-acrominalis produces a small swelling under the acromion process. An exudation of the bursæ subscapularis, "providing it does not communicate with the joint," will produce a swelling in the axilla.

Now what I wish to call your attention to is this: That we might suppose and reason that an exudate or fluid within the capsule, would produce the largest swelling of the shoulder, on account of the large space to be filled; but it is not so, an exudation in the subdeltoid bursæ will produce the appearance of a larger swelling of the shoulder; on account of the accumulation of the fluid in the bursæ, the deltoid is lifted up from the capsule.

If there is fluid within the capsule, the deltoid is not lifted up, is not arched, the strong ligaments prevent that. The capsule gives away the easiest behind, and here it is, under the spine of the scapula upon the posterior side where the fluctuation can be felt most distinct. Do not be mislead to diagnose at once, by a swelling of the shoulder over the deltoid, an inflammation of the joint.

This has to be done by other symptoms. And by what symptoms can we make a certain diagnosis of inflammation of the joints themselves? Well it is this: By the fixation of the joint, just as in inflammation of the hip joint, the pelvis and the thigh must be kept in a positive and relative position, so here; with the humerus and the scapula, they must be fixed in positive positions to one another. As we say in hip disease, the pelvis moves with the femur: we say in shoulder joint disease, the scapula moves with the humerus.

[TO BE CONTINUED.]

Proceedings of Medical Societies.

Article LXII.

ST. LOUIS MEDICAL SOCIETY.

Taken by the Journal's Stenographic Reporter.

Saturday, March 31st, 1883.

Case of Rupture of the Ileum without lesion of the Abdominal Parietes. By Dr. F. J. Lutz.

It cannot be conceived how any serious injury can be inflicted upon the abdominal walls, without involving some of the contents of the cavity. On the other hand it is well established that the most fatal lesions of the abdominal viscera may occur as the result of direct violence without any appreciable external wound. The annals of surgery contain the records of the rupture of the spleen, liver, stomach, etc., without lesions of the parietes. Some of you will remember that in May, 1878, I reported to this society a case of rupture of the jejunum caused by a heavy piece of coal falling upon the abdomen, in which there was no external wound, and the specimen before you is another illustration of rupture of an intestine, the ileum, from direct violence without any appreciable lesion to the walls of the abdomen.

The young man from whom this specimen is taken was nineteen years old and a laborer in a lumber yard. He was so unfortunate as to be caught under quite a number of boards, which struck him in the abdomen. This occurred on the 24th of this month and I saw him the next day, about twenty-four hours after the occurrence of the accident. His pulse was quick and feeble, his countenance pale and pinched; he vomited incessantly greenish, foul smelling liquid, complained of unquenchable thirst and great pain in the abdomen. His respiration was superficial, quick and labored, his abdomen very tympanitic and his extremities cold, whilst he complained of great pain, especially in the right ileo-cæcal region, which was much increased by pressure, yet it was found that the entire abdomen was painful on percussion. There was not even an abrasion of the skin; no fracture

of the pelvis; he had passed his urine several times and emptied his bowels once since he was hurt.

The patient was so evidently moribund that palliative treatment only was instituted, consisting of the hypodermic injection of morphia, and he died about six hours after I first saw him.

The results of the post-mortem examination, which I made on the following day, may be briefly summarised as follows: There were a few abrasions of the skin of the lumbar region. On making an incision from about six inches above to about three inches below Poupart's ligament on the right side in a diagonal direction, some extravasated blood was found in the subcutaneous cellular tissue. On opening the abdominal cavity through this incision and increasing the field by a second incision made at a right angle to the first, the intestines situated in the ileo-cæcal region were found to be firmly adherent to each other by exudated material, and on severing this connection between the different coils a rent was discovered in the ileum about four inches above its junction with the cæcum. As you will see by examining the specimen, the entire circumference of the bowel is involved in the tear. The cavity of the pelvis was filled by the contents of the intestines which had escaped through the opening. The entire parietal and visceral layer of the peritoneum, gave evidences of recent inflammation, but there was no injury to any of the other viscera.

The intestine must have been caught between the weight and brim of the pelvis during the accident, and torn.

The treatment of such a case as this, if seen at the very outset, basing the prognosis upon a rational interpretation of the symptoms, should consist in a free incision and reunion of the bowel.

DR. ATWOOD.—In reference to the specimen exhibited by Dr. Lutz, I will say that I saw a case, not of rupture of any abdominal viscus but of fracture from external violence without a rupture of the skin. I have seen cases of rupture from external violence without fracture of the wall of the abdomen, but this was not one of that character. While I was in the army, a captain, in battle at Fort Scott, attempted to dodge an almost spent cannon ball, which struck him about the junction of the middle and lower third of the tibia and produced a slight abrasion yet fractured both tibia and fibula; it was a somewhat similar case.

Dr. Stevens.— I have never witnessed a case exactly of that kind, but I attended a case where there was a rupture of the bladder without any external injury. This accident was the result of a coal miner attempting to lift the axle of his wagon. The wheel came off and he attempted to raise the axle to put the wheel on by himself, and ruptured his bladder so that the urine was extravasated into the cellular tissue, and he died as a consequence of it. There was no external injury at all.

Dr. Pollak.—Old Dr. Baumgarten died from a fall over the dashboard of his buggy. He was trying to rein in his horse when he fell over the dashboard and ruptured the bladder. There was no external injury at all. He died from extravasation of urine.

Dr. Love.—I wish to report a case that was recalled to my mind by the remark of a member two or three meetings ago regarding the hæmorrhagic diathesis and its relation to malaria. Some time ago a gentleman sent for me. He had had a tooth pulled, it was the last molar in the upper jaw. The first time I saw him was in a distant town, and knowing that I was there he consulted me there for a hæmorrhage from the tooth cavity. He told me that the tooth had been pulled the day before in St. Louis, by a prominent dentist, who checked the hæmorrhage at the time with the usual styptics, but it began oozing that evening after he got on the train to leave the city, and so continued during the night and after arriving at the town where he then was, the bleeding became quite profuse and disturbed him, so that he consulted me. I applied a piece of absorbent cotton saturated with tannin over it and held it in position with some chewing gum. I remained there until the next day and there was no further trouble during that time. I returned home and shortly afterwards he also returned. He then sent for me in the evening at about eleven o'clock. He said that it had been oozing freely again, and when I saw him it was welling up, the flow of blood was formidable. I happened to have a bottle of chromic acid in my pocket, and I applied a small quantity. I was afraid to apply very much for fear of producing a great amount of sloughing of the gum and the tissue round about. I feared it somewhat, as one cannot always control the action of chromic acid. It acted very nicely but in the evening of the next day I was sent for again, and I sawhim probably a dozen times the next day. I applied vari-

ous styptics without producing any permanent result, and finally concluded to apply pressure. I made a compress of punk such as dentists use, which is of itself a styptic, and placed it over the bleeding point, and then made a mechanical contrivance by which means as much pressure on the bleeding point could be made as was desired. This controlled the hæmorrhage for a time, but after a few hours it became loose in consequence perhaps of the receding of the mucous membrane of the gum. I released the pressure and the oozing again commenced. That apparatus was applied three or four times I suppose, and I finally took the patient to my own house where I could have him constantly near me, and for two nights I tried to stop the bleeding, but it continued in this way for four or five days when I called a consultation, appreciating the fact that the condition of the man was becoming serious as he was now greatly reduced. Dr. Hodgen saw the man, and also Dr. Mudd, I think. The result of the consultation was, that various methods of treatment were suggested. The white hot iron was discussed, and it was also suggested that a small quantity of chromic acid should be used. Dr. Mudd favored a larger amount, that it be used freely, with enough water to render the acid liquid. It was applied thoroughly and after its application there was no more hæmorrhage. I watched the eschar very closely, but it adhered firmly. We gave tonics and nourishment to make up for the loss of blood; it having become so watery that I feared the patient would die from exhaustion. At the end of three weeks the eschar loosened and came away, and the surface beneath was entirely healed. I think the eschar from chromic acid is more firmly attached to the surface beneath it than is any other eschar. It clings longer and for that reason, in a case of hæmorrhage it is the most valuable, because it forms a stopper to the bleeding vessels. In capillary hæmorrhages I will make henceforth at the very outset a thorough cauterization of the part with chromic acid. With regard to the case, it is evident that there was a hæmorrhagic diathesis dependant upon a depraved condition of the system. He had had an attack of malaria and his digestion was not good. Under the use of tonics etc., he soon regained his health, and since then, although with great trepidation, has had one or two teeth removed without any serious result. They almost dropped out. In each case there was a bleeding surface but the vessels contracted and no hæmorrhage of any consequence resulted. Now if I had not

been able to follow this case up afterwards it might have been put down as a case in which there was a tendency towards hæmorrhage. I will say as regards his previous history, that he had had during his life several such experiences, when every little wound would be followed by hæmorrhage, too profuse for the character of the hurt. And I think many of the so-called hæmorrhagic diatheses are explainable in this way. I don't know that the case is particularly unique, but I must say it was most interesting to me during the time it was in progress, and it has given me wonderful faith in chromic acid for the relief or checking of hæmorrhage.

Dr. Watkins.—I would like to ask the docter if quinine was administered to the patient during the continuance of this hæmorrhage.?

Dr. Love.—Yes, sir; in large quantities. The therapeutic measures were all thoroughly considered and administered.

Dr. Pollak.—I ask, that I may be permitted to add a few cases of Hæmatophilia, which occurred in the early days of my practice in this city.

1. A child, about one year old, was suffering from difficult dentition, which caused convulsions frequently. It was thought that scarification of the much swollen and painful gums, would arrest the convulsions, and accelerate the protrusion of the teeth. I was not disappointed in this expectation, the convulsions never recurred after two or three incisions into the gums. But small persistant bleeding ensued from this trivial operation, which resisted every remedy hitherto known. Mechanical appliances, styptics, even the actual cautery were tried, but all in vain. Drop by drop blood would filter through dressing and eschars, until the child became entirely exsanguinated, and it succumbed in six weeks. I had the aid of my friend the late Dr. Pope and other noted practitioners of medicine and surgery, but all to no purpose.

2. A little while after, I met with a case of bleeding from the umbilicus in an infant of three days old, after the cord had became detached. Dr. Pope and other surgeons were co-attendents in this case. Hæmostatics of all kind, ligation of the umbilical artery, were tried but all in vain, the child died in three days from the loss of blood. This was a very trying case, as it was an only and long hoped for offspring, of a well-to-do family.

3. Another case occured more recently. It was that of a lad, aged thirteen. Who was stung by a bee over the eyelid, causing a traumatic erysipelas and ultimately entire sloughing of the integuments of the lid. With the subsidence of the inflammation and the ensuing cicatrization, an ectropium was the inevitable consequence. The free tarsal margin of the lid became adherent to the brow, and thus two-thirds of the eyeball remained uncovered, and exposed to atmospheric influences, and to foreign bodies floating in the air, besides creating a most hidious deformity. A plastic operation was decided upon, and very successfully performed. The flap was taken from the forehead and secured by fifteen fine sutures. No bleeding worth nothing occurred during this tidious and delicate operation. Bandage and proper dressing were applied, and the patient left in a very satisfactory condition. In my visit a few hours later, I noticed the bandage stained with blood, I quickly removed the dressing, and to my great chagrin, I found the flap raised from its well adapted position, blood oozing freely from between the sutures, which at last gave way entirely owing to the pressure of a large coagulum, which had formed under the flap. The flap had to be sacrificed, in order to stop the bleeding. The operation was a failure. I have since learned, that the boy had a hæmorrhagic diathesis, which has manifested itself in various other forms.

4. A fourth case came under my observation, during the war. It was that of the late Major Maline, Advocate General on the staff of Maj. Gen. John Pope. He was about forty-five years of age, of splendid physique, of good family record, of active and regular habits, and perfectly temperate, of pallid complexion, but sound to the core in every way, never complaining, with the exception of occasional moderate epistaxis. One night the epitaxis was very excessive and absolutely alarming. Ergot internally as well as subcutaneously remained without effect. Mineral acids, ice, tampons steeped in Monse's solution proved worthless. A large quantity of blood must have found the way into the stomach, for the evacuations from the bowels contained large coagula. Stimulants and tonics had to be given to meet the threatening inanition. It gradually stopped I presume from absolute exsanguination. By order of the Medical director, he was put on board a steamer for the Missouri. As soon as he reached the plains, he mounted a horse, and kept in the

saddle until he reached Santa Fe. New Mexico, much improved in health and strength. His book, "4000 Miles, or six months in the saddle" is a pleasant reminescence of his convalescence and ultimate entire recovery, from an apparently pernicious disease.

Dr. Meisenbach.—This is an interesting subject and I will relate a case of epistaxis that occurred in a lady seventy years of age, who came under my notice last fall. I was called in consultation in regard to her condition. She was bleeding very rapidly. I used internally the fluid extract of ergot and other means; I applied pressure over the articulation of the lower jaw, trying to depress the internal maxillary artery. The bleeding in two hours ceased. I had the pressure kept up for a number of hours, and I think in this case it did good. Whether this assumption is correct or not I am not able to state, not having tried it in any other case. I mention the fact, as some one may have had a similar experience.

Dr. Laidley.—I reported, some three years ago, a case which came under my observation; it was seen by Dr. Hodgen and Dr. Gregory, being a somewhat remarkable one. The patient was a little girl eight years of age, and part of the family history was that the mother was found dead one morning, no one knowing what time she died and the cause of death being also unknown. This child was taken with repeated hæmorrhages. Several days would elapse and then there would be bleeding from the nostrils, and underneath the skin there would be ecchymotic spots, probably two inches across in their largest diameter. This was observed over many parts of the body. The eye was examined and it was found that there was a clot of blood in it. While the patient was under my care, for two or three weeks probably, this ecchymotic condition showed at its greatest advantage in coloring; after four or five days it began to decline, and in the course of two or three weeks it had entirely disappeared. The remedies which were used were the preparations of iron etc., to control the general hæmorrhage, and cold applications to the nostrils or plugging them, but still the child continued to bleed for a time. I don't know what remedies caused it, or whether it was simply the work of nature, but the bleeding finally stopped and the child gradually grew strong as usual. Some months after this it commenced again, and coming under my care, I requested Dr. Hodgen to see

the case with me. I don't know but that Dr. Love saw the case also. At any rate Dr. Hodgen recommended that the child should eat sour kraut and lemons as a preventive. At any rate the remedy acted splendidly, as the child went longer without the trouble than it had ever gone before. What the rationale of the treatment was, I am not able to say, but the remedy was given and seemed to have the desired effect.

DR. ATWOOD.—That must have been a scurvy. The child was of scorbutic diathesis.

DR. HURT.—I was very much interested in the case reported by Dr. Love, and I am free to say that I was interested not only from the results of the application of the remedy, but in the theory of the therapeutic action of the remedy. I think it was a very appropriate remedy—the chromic acid; but I was a little surprised to hear the Doctor affirm that he would never attempt to treat a case of the kind with any other remedy, for the reason that I have no doubt but what Dr. Love has often treated cases successfully with other remedies, what would be materially less potent in their effect upon the tissue. I remember a case of hæmorrhage after the extraction of a tooth, which was quite severe. At the time I saw the case the bleeding had been going on for some six or eight hours and seemed quite copious. It was successfully arrested with alum, after the failure of persulphate of iron. The alveolar cavity was filled with it and the hæmorrhage ceased immediately, and there was no further trouble with it. In regard to the case reported by Dr. Pollak, it occurred to me that the treatment in the case which ultimately proved successful, was not perhaps thoroughly understood; and I must confess I don't just exactly understand the philosophy of it myself. The atmospheric pressure in a high altitude is less upon the body and upon the arterial circulation than it is in a lower altitude, and I cannot quite understand the philosophy of the success of the treatment—the treatment in this case of sending a man into a lighter air—into a lighter atmosphere. Still, of course, as it proved successful, we would like to be possessed of the knowledge of why it was so.It seems to me that he might have ridden in any other direction just as well. The subject of hæmorrhage is a very interesting one, and especially the question of the hæmorrhagic diathesis; and probably the most interesting hæmorrhages in this condition is hæmorrhage from the uterus, in a case

where there is a diathetic tendency to hæmorrhage; and we are as apt to find a diathesis developed at this point as at any other, perhaps more likely. Not very long ago I was called to a case of hæmorrhage from the uterus, the patient stating that she had been bleeding for about three weeks. She was blanched in her appearance, and was losing blood then in just a moderate amount. I didn't just exactly understand the history of the case, or the character of the patient, and I had my suspicions aroused that perhaps an abortion had been performed. I was anxious to satisfy myself as to the cause of the hæmorrhage, but I could not do so. I examined the womb and found it slightly enlarged and soft under the touch. The cervix was sufficiently open to admit a probe with a considerable amount of cotton wrapped around it. I could not satisfy myself that an abortion had been produced and I attempted to arrest the hæmorrhage by internal treatment and resorted to the use of two parts of the fluid extract of ergot and one of the tincture of digitalis; directing a teaspoonful to be taken at a dose, at the same time I ventured to inject the uterus with hot vinegar, as hot as it was possible for the patient to bear it without being scalded. This seemed temporarily to control the hæmorrhage, not entirely, for it began pretty soon to return. I kept her under the influence of ergot and digitalis. I then attempted to inject the uterus with a weak solution of chromic acid, probably I made it too weak. Injecting the uterus, as you are aware, in this condition without a well dilated cervix, is a hazardous practice, but I succeeded in throwing a few drops, as I supposed, into the body of the uterus, and almost instantly the patient complained of intense pain. In order to control the pain I gave her a hypodermic injection of morphia as soon as I could, and as she seemed to be going into a state of collapse I gave her some whisky also. She recovered from the depression or shock and there was a temporary arrest of the hæmorrhage; but when I saw her again on the next day, she was still bleeding, but slowly. I then made an application of the persulphate of iron on a probe, the probe being wrapped with a little cotton. I passed it into the uterine cavity and turned the probe gently from side to side, so that I would sweep the entire surface of the cavity as near as possible. She again immediately exhibited symptoms of collapse, and I was again compelled to resort to hypodermic injection of morphia. After this I resorted to such remedies as would relieve any obstruction of the bowels, and as

much as possible relieve the tardiness of the venous circulation in the liver, and the hæmorrhage ceased and she recovered.

DR. POLLAK.—How much chromic acid did you use?

DR. HURT.—I used about a 20 per cent. solution of chromic acid in water, and diluted it, perhaps one-half, injecting probably eight or ten drops into the uterus, and such were the symptoms following it that I became alarmed, and supposing that I could make the application upon the probe with better success, I attempted that, but unfortunately I was no more successful so far as the production of shock was concerned. The shock was very profound, so much so that I resolved not to repeat the practice again.

DR. LOVE.—I simply wish to refer to the remarks or rather the criticism of Dr. Hurt, regarding the use of chromic acid in cases of hæmorrhage. The Doctor certainly misunderstood me. I said or meant to say that I would use it in all cases which demanded it—in all formidable cases. I most assuredly think that where there is a bleeding surface that can be seen, where it is within reach, where the application can be made as desired, that chromic acid is not a formidable agent. I use a saturated solution, just enough water to produce deliquescence. I think it is one of the most efficient caustics we have, and if properly applied, is more apt to leave a sound surface beneath the eschar than any caustic we can use. Probably the reason for this is that the chromic acid produces an eschar which keeps the air completely from the surface beneath, thus enabling the healing process to go on without interruption. I must certainly say that I would not use chromic acid of any strength, as an injection into the womb.

DR. MOORE.—Two cases of epistaxis in my practice, and another of uterine hæmorrhage, about such as Dr. Hurt relates, was relieved, not in an hour or a half an hour, but in five minutes, by a remedy that I am surprised has been overlooked—the hypodermic injection of ergotine. In a case of epistaxis in a patient of, I think, hæmorrhagic diathesis, certainly an anemic, nervous woman, the hypodermic injection of two grains of ergotine stopped the hæmorrhage in three minutes and it did not return. I gave a little morphine afterwards. In the practice of a friend was a case which he detailed to me a short time ago,

somewhat such as Dr. Hurt reported of uterine hæmorrhage. A similar injection of ergotine stopped the hæmorrhage within a few moments. I certainly think that the hypodermic use of ergotine is by far the most preferable way of getting its hæmastatic power to work. The effect of this remedy in these cases was almost instantaneous, and is was permanent. In this connection, although we have full reports on these subjects, I want to report two cases of profuse sweating. One in a man forty years of age, who came to me with the statement that he was in perfect health with the exception that he had night sweats every night without exception, and to such an extent that he would saturate his night clothing. This had been going on for two years. After trying quinine in full doses, twenty grains at bed-time, and sulphuric acid, atropia and other remedies, I suggested a dessertspoonful of fluid extract of ergot about half an hour before bed-time. He told me that after the second dose he never had any more night sweats. Three weeks more elapsed and there has not been the slightest return of the trouble. The other case was that of a boy fifteen years of age, who came to me for a similar condition. He had no organic trouble. I gave him fluid extract of ergot also, and it entirely prevented the trouble, and he has not had any since. I asked him to report if any sweat occurred and so far he has not returned. It seems to me that the results were wonderful, and I was surprised that no one had discovered it. It seems to me that it is one of the most feasible therapeutic agents that we have in the treatment of night sweats. After these cases I looked up the subject and was a little surprised to find that the authorities do not mention ergot in this connection. Ringer says it has been known to relieve sweats and that is the only allusion that hemakes to it.

Dr. Ohmann-Dumesnil.—In regard to the ergotine for night sweats in phthisis, I saw it mentioned in the medical journals two years ago. Perhaps the Doctor consulted the older medical works. It is mentioned in those of a more recent date. I remember distinctly seeing it specified in quite a number of medical journals. I think it was a Philadelphia physician who was speaking of it at the time. I had occasion to use it in a couple of cases at that time, with quite an amount of success. This was about two years ago.

DR. MOORE.—I claim no priority at all in the matter. If these articles appeared they escaped my notice.

DR. MEISENBACH.—I would like to ask Dr. Hurt if he does not think it would probably have been better to have dilated the cervix before applying the chromic acid. It seems to me that by adopting this method he would not have run any great risk. Then the question might be asked whether this was a pure case of hæmorrhagic diathesis, or whether it was a case of pulpous condition of the mucous membrane which we often find in the uterus. This may have been the cause of the trouble and would account for the failure of the astringents to act efficiently. If the membranes had been scraped with a dull curette and the remedy applied, it would probably have effected a radical cure. This seems to me, would have been the rational treatment. In regard to the injection of the uterine cavity with fluids of any kind, I think it was most hazardous. Even the most innocuous of all liquids, water, I very much fear to inject without dilating the cervix, being afraid of producing secondary peritonitis.

DR. HURT.—At the time when I made the injection, I made an examination and concluded that there was suffient dilatation to permit the fluids to return, or of course I should not have injected.

SATURDAY, April 7th, 1883.

Dr. Rumbold being called upon to make some report of the proceedings of the Kentucky State Medical Society, which he had recently attended, said:

DR. RUMBOLD.—Mr. President: I had the honor to receive an invitation from the President of the Kentucky State Medical Society, Dr. Price, to read a paper on the Treatment of Chronic Nasal Catarrh. I accepted the invitation, and had a very pleasant time. There were about one hundred members in attendance. A very extraordinary case was reported by Dr. McCormack, of Bowling Green, president elect of the Society. Dr. Wilson had been speaking of the effect of injuries on the head. He was followed by some other physicians, who spoke of the effects of depression upon the brain; and afterward Dr. McCormack related a case that transpired under his own eye, and was now living in Bowling Green, as were also his father and mother.

When this boy was ten years of age he was struck on the head with a hammer. He fell to the floor in an unconscious condition. He remained so for a few hours, but finally consciousness returned, and apparently he was not badly hurt. There was, apparently no alteration in his actions or character until he was nineteen years of age. But nine years after he married, and a few years after he commenced to be very talkative; his character changed. He was sometimes morose, but most always talkative and sometimes quarrelsome, and as such he was known to the whole town. Finally he got so very troublesome that he was taken to Dr. McCormack to be examined, in order that he might be sent to an asylum. While making this examination the doctor put his hand on the patient's head, and felt a depression; he also noticed that the patient shrank under the slightest pressure. The doctor recommended that he should be trephined at once, as he thought that might be the cause of the man's peculiarity of character. The patient, after some time, probably the next day, was chloroformed, and he took out two pieces of bone from his head, and filed off the corners left by the two openings, overlaping one another. Now comes the strange part of the history of the case. When the man recovered from the effects of the chloroform, the whole period from the time when he was ten years of age to his twenty-sixth year, was contracted into a few hours or at most a day. He had acquired some property, but had forgotten it; he did not know that he was married, and in fact he did not know anything that had transpired between those two dates. It is the most extraordinary case that I ever heard in my life, and it would not be well to repeat it except for the fact that this man is alive and living at Bowling Green. I am going to have the complete history of the case for my Journal, and of course it will be read with interest by every medical man in the world. Here there was sixteen years of oblivion.

Dr. Hurt.—Mr. President: As the subject of hæmorrhage, or rather, diathetic hæmorrhage, was under consideration at the last meeting, and during the discussion the subject of uterine hæmorrhage was drawn in, I thought that perhaps it might be interesting to supplement the discussion of that subject with a couple of cases that fell under my observation during the week.

On the 3d instant, I believe it was, I was summoned to a lady in the western part of the city, between 28 and 30 years of age,

I suppose, the mother of three children, who considered herself in the third month of pregnancy with the fourth child. In the morning, after taking some considerable exercise, she was seized with uterine hæmorrhage. By the time I got to her the hæmorrhage had ceased. I found a large quantity of blood in the chamber, and quite a large quantity, also, in the sheets; and when I came to make an examination I found that the vagina was filled with blood clots, as was also the uterus as far as I could explore it. The uterus appeared to be quite out of my reach, so far as the body of the organ was concerned, and I found it very difficult to bring it within reach, and as the hæmorrhage had ceased, and no fœtus had been found, nor any fœtal sac had been found in the vagina, nor in the blood clots that we had under our observation, the inference was that the fœtus and the fœtal sac still remained in the uterus. I plugged the vagina and sent for a prescription of ergot, as the os uteri was quite well dilated. The hæmorrhage had been so very profuse that the patient was completely exhausted from the loss of blood. I sent for ergot supposing that under the efficient action of the ergot the contents of the uterus would be expelled. Fortunately for the exhausted lady, under the aid of the medicine and tampon there was no further hæmorrhage, and I was at a loss how further to proceed, for the reason that the presumption was that the uterus had not emptied itself, and the patient being some distance from my house, I apprehended that there might be a return of the hæmorrhage at any moment. Under these circumstances some of our best authorities recommend the insertion of the hand into the vagina so that the fingers will reach the uterus, and relieve her of the fœtus forcibly; other authorities, in my estimation quite as good, advise, when there is no active hæmorrhage, and no absolute demand for this remedial interference, to delay the operation of forcibly emptying the uterus at this time, or at that stage of the pregnancy, it would necessitate the use of chloroform, and chloroform has the reputation of rather favoring and facilitating hæmorrhage than otherwise. At any rate I did not choose to administer it. I kept my patient under the influence of ergot, and saw her again the next day. She had had no more hæmorrhage. I took out the plug and inserted another, and gave directions that there should be perfect quiet. On the evening of that day the patient seemed quite cheerful, and had no pain. In the meantime, however, on

the morning of the second day it was reported to me that the fœtus had been found on the floor where it had been shaken from the sheets. I have the specimen here and present it to you. It is a fœtus of about the beginning of the third month, perhaps. Now, it is possible that the fœtal sac might have been thrown off at some time, under the influence of the uterine contractions. I had almost decided to trust her to rest, but upon consideration I concluded to make an examination, which I did on the evening of the third day after I saw her, as I was not very well satisfied. The uterus had sunk a little lower in the pelvis, and I could pass my finger into the os, and I found that there was a sense of thickness there that did not exactly satisfy me that all was right. I got the consent of the lady, and introduced a sound along my finger and carried the point of it into the os uteri, and some distance up, and as I explored with the point of the sound I felt some object between the point of the sound and my finger—it was a membranous substance, and being anxious to ascertain what it was, I carefully, with all the force I could safely use, pressed the point of the sound upon my finger and commenced to pull down, and the lady immediately complained of pain, and I was hesitating in my own mind whether I should pull or not, or whether I had hold of the lip of the os, when I felt it drop a little, and I kept on pulling, and I soon became satisfied that it was nothing that appertained to the organ of the female, and after pulling for some time it came away, and proved to be the fœtal sac. My patient had no further trouble after that.

In addition to that case I have here to report the history of a case that I encountered this morning. I was called about three o'clock this morning to attend a lady in labor, whose history, so far as I know, is about this: About a year ago she consulted me, and reported that she had been married some four years, and had had two miscarriages at about the seventh month, and lost her children. She had been treated for some uterine trouble before she saw me, and she looked a little careworn and somewhat emaciated. She was a slender woman, about 28 years of age, I suppose, and in conversation with her I learned that both she and her husband were very anxious to be the progenitors of a living child. I gave her some advice, and some three or four months later the husband reported to me that the wife was pregnant, and placed her under my observation and care. This

morning, as I remarked before, I was called to attend her at full term, and she gave birth to a living child, weighing ten and a half pounds, after a somewhat tedious labor. The greatest trouble in the parturition, so far as the expulsion of the child was concerned, was found to be after it had reached the vulva. The vulva would not readily permit the child's head to pass, and she suffered for some time, and I began to apprehend that there would be some laceration of the perineum, but I think she escaped, without any very serious laceration, at least. I was delaying somewhat before separating the child from the cord; and as soon as I could, after the delivery of the child, I administered a dose of ergot, the fluid extract, and was again waiting, as modern authorities seem to think that it is better to wait, and not be in too great a hurry in separating the child from the placenta, although the child did not seem to be in any great need of this care for its preservation; while waiting I noticed that the mother was flooding very copiously, and I immediately separated the child, and administered the second dose of ergot, and proceeded to deliver the placenta; that was to be the first step in the treatment of the case, but to my regret I found that the placenta was quite adherent, and not only adherent, but extremely rotten—so rotten indeed that, as you will see, I have torn it all to pieces in trying to get it out. I first discovered that it was rotten on making the cord tense, and in trying to make the necessary tension to remove it—not unusual tension; however, I felt it giving way under my finger—it broke in the same way as we can feel a cord which is made of several threads break when one thread gives way—you are sensible of the giving way of the thread. You will notice that this cord has some evidences of disease in it. The placenta was adherent, and the posterior margin seemed to be separated. In my efforts to get hold of it I succeeded in getting my hand entirely into the uterus. One half of the posterior wall of the uterus had fallen in, as was indicated by the partial involution. I rectified that, however. At the same time I discovered that the uterus was well contracted. The trouble about its contraction, however, was that it contracted irregularly. I finally succeed in getting away the placenta, and the hæmorrhage immediately subsided, and it was a question with me whether the subsidence of the hæmorrhage was due to the fact of the extraction of the

placenta, or to the other fact, that there was no more blood to be lost, for my patient was in a fainting condition. She was in what might be called a collapsed condition; she was pulseless. At this juncture of the treatment I administered toddy in hot water, and pretty soon she began to rally. Contrary to my advice, she insisted that her child must be put to her breast. I warned her of the danger, and told her that there was no necessity for it; she would have the child put to her breasts. At that time the uterus was contracted, and there was no more hæmorrhage; but the excitement of the act of nursing was too much for her, and her pulse began to sink again, and her face and hands and the surface of her body became cold. I had the infant removed, and gave stimulents again. Among other things I gave her hot coffee, pretty strong, with some milk, and had the good fortune to see my patient rally again. After the placenta was removed I threw it into a large, light bowl, and called for something to aid me in getting out the blood clots that lay, as it were, in heaps about the nates of the patient. I dipped up a night bowl full, including the placenta, besides an immense quantity of blood that had been absorbed by the sheets. I think the patient must have lost half a gallon. May be I am mistaken; but I think it was the greatest amount of blood I ever saw escape from a patient, in my experience, in any case of labor. I am happy to say that the patient is doing quite well.

[Dr. Dean presented a specimen of diaphragmatic hernia of the stomach, gastro-splenic omentum and splenic flexure of the colon, which he did not wish reported, as he had presented it to another society that publishes its proceedings.]

Dr. Johnston.—I did not catch the period at which the case of abortion reported by Dr. Hurt occurred; was it four or five months?

Dr. Hurt.—Three months.

Dr. Johnston.—Now, Mr. President, there is nothing more common in obstetrics than from the third to the fourth month to meet with abortion; and when I entered the profession forty years ago the writers of that day led a young man to believe that he must go to a case of abortion with fear and trembling, they made such exagerated statements in regard to the hæmorrhage. It was enough to frighten any young man. Then, also, there was the statement that if air got into the cavity the patient

would die immediately, either at time of abortion or at full term. Now as regards this abortion, there need be no uneasiness about it. There need be no unusual anxiety about it. An experience of forty years has proved to me that fact; the fœtus may be expelled, and unless there is excessive hæmorrhage you need not trouble yourself; and if the womb is not contracted, or there is an attachment of the placenta, you will have no hæmorrhage at all, or very little. All that you need do is just let your patient alone. If the chorion, or a portion of the placenta does not come away in the course of a few hours or days, let it alone, unless there is hæmorrhage, and then theremust be a detached portion of the placenta, and if a part is detached, decomposition may go on and it become necessary to get it away. It is an impossibility, as the gentleman said who reported this case, that some gentleman recommend in such case to put the hand into the womb at the fourth month. It is impossible.

DR. HURT.—I said put the hand in the vagina.

DR. DICKINSON.—In regard to the case reported by Dr. Rumbold, I would like to call Dr. Stevens' attention to it, and ask if he would consider that a case of double consciousness, would also like to hear his experience in regard to cases of this kind.

DR. STEVENS.—There are remarkable cases on record of what might be called automatic cerebration from epilepsy. There is a case on record by one of our specialists of a case of an indivual laboring under epilepsy who transacted business for some length of time, went fron New York into Conneticut at a differen town—to Hartford, and lost the consciousness of transacting this business. It was all correctly transacted. That is, perhaps, the most remarkable case that I recollect. I can not account for it at all; as to its being a case of double consciousness, I do not know whether it would come under that head or not; it seems to me it would not. I do not know that I could give anything without an examination of the records, but I would take this to be a case of epileptic condition in which this person remained from the time he was ten years old until the operation. I do not know that, at this time, I could answer the doctor's question.

DR. JOHNSON.—What is understood by double consciousness?

DR. STEVENS.—I can not fully answer that at this time. It

is a condition in which a person performs automatic actions that appear to be actions of consciousness. Is that the Idea, Dr. Dickinson ?

Dr. Dickinson.—In a word, Mr. President, cases are on record in which persons, on account of some violence, perhaps, passed into a state of entire ignorance of what has transpired, or what transpired previously, and then again, in the course of time they will come out of this condition, and they are ignorant of what transpired while in the normal condition, but they have a recollection of what transpired previous to that state, that is the condition to which, as I understand, has been applied the phraseology of double consciousness.

Dr. Johnston.—That is a new departure in medical philosophy. Consciousness is to be in possession of the senses and relations that surround us. That is according to Sir William Hamilton, Kant and Comte. Now we are either conscious or not conscious. I am now conscious that the room is full of gentleman; now, I receive a blow, and the coördination of my relation to these gentlemen is lost, it is not double consciousness; it is destroying a portion of my consciousness. So that this doctrine of double consciousness can not be maintained.

Dr. Ohmann-Dumesnil.—I do not know whether the doctor read the case of double consciousness which has been observed in the southern part of France, for twenty-two years a young woman who, for twenty-four hours is in a normal condition, and then for about twenty-four hours she is in a state of double consciousness. And during the second period she is completely ignorant of what transpired during the first period, but when the state similar to it returns she remembers what occurred during the previous time. There are two distint states which she remembers each in its turn.

Saturday, April 14th, 1883.

Dr. Mulhall.—I would like to report a case which was interesting to me on account of its rarity, and also as showing the value of Laryngoscopy. Three weeks ago Dr. Boisliniere sent me a patient for laryngoscopic examination. His principal symptom, and it was annoying enough, was extreme fetor of the breath.

He had already been treated on the theory that the fetor arose from the stomach, he had tried charcoal, listerine and the various antiseptics without relief. On examining his nose I found that in the vault of the pharynx there were some crusts adherent,and a great deal of chronic inflammation. I thought that I had discovered the source of the fetor, but upon reversing the mirror and examining the larynx, particularly the trachea, I found a condition which much better accounted for the fetor than the condition which I had found in the nose. I, however, first washed the nose out thoroughly, and thoroughly drenched it with listerine afterwards in order to remove that source of fetor What I saw below was an ordinary—not a very ordinary condition either—a chronic laryngitis and tracheitis, which was rather unusual. The whole larynx was of a uniform dark red color, unrelieved by a single bright spot, and in the trachea there was a large aggregation of follicular masses, each about the size of a pin head, adhering to the walls of the trachea, thickly coating the cricoid cartilage. The gentleman was about twenty-three years old, he had been in this country about six months; being a native of Germany. I mention this because it has something to do with the subject.—He told me that he had been subject to nose and throat disease for a period of five years, whilst in his own country, in fact had been under the treatment of Professor Rosebeck but that he never had fetor until he had been in this country one month, he has now been here six months.

The family history was perfect in regard to scrofulous or lung disease. I inquired very closely with regard to himself, there was no history of syphilis. The case is interesting from the fact that this condition very seldom occurs and that the cause of the foul breath would without the laryngoscope have never been discovered. It is a chronic condition, the effect of laryngitis and tracheitis. Dr. Cohen in his book on diseases of the throat mentions the fact that he has seen several cases but they were all in foreigners. The subject is one that has received little attention. I don't think Dr. Mackenzie mentions it in his book. I advised this gentleman, in view of the fact that he had chronic inflammation of the larynx and trachea for five years without fetor, and then this symptom presented itself in a month after he arrived in this country, that perhaps it was better that he should return to his own Country, other circumstances also made it agreeable for him to return and he took his de-

parture. I mention this because I don't think I would have been able to have cured him. This affection is almost hopeless. I have seen some other cases but not in this country.

Dr. Pollak.—What was the cause of fetor.?

Dr. Mulhall.—The decomposition of the crusts in the trachea.

Dr. Green.—Mackenzie in his book, if my memory serves me right, does not mention a case of this kind which has been complicated with fetor, and I think it would have been right for the doctor to have tried to see what he could have done by treatment in this case. In such a case I think the right treatment would have been to perform tracheotomy low down, and then the nose could have been treated antiseptically.

Dr. Mulhall.—There is one case on record a case which Dr Frænkel of Berlin had under treatment, of a similar nature—a lady who suffered from this affection in the nose, larynx, pharynx and trachea, and he was unable to afford her any relief. I believe that that is the only case on record there.

Dr. Pollak.—What proof is there that the fetor came from the trachea and not from the nose.?

Dr. Mulhall.—The fact that I disinfected the nose thoroughly and the fetor was still as strong as ever.

Dr. Green.—After injecting the nose could you still discover fetor.?

Dr. Mulhall.—Oh, yes, very strong.

Dr. Green.—I think that fetor will actually be maintained for a long time. I would have put a tampon in the nose—in the posterior nares and thus have stopped up the whole nose, so that nothing could come through it and then if there was fetor we could be sure that it came from the trachea. We are not sure that the Listerine that the doctor used was sufficient. You can't take away fetor at once.

Dr. Mulhall.—I argued this way; in the first place there was very little disease about the nose, most of the disease seemed to be in the larynx and trachea and I first washed all the decomposing matter from the nose and then disinfected it thoroughly—then finding that the fetor was as strong as ever, and taking into consideration the fact that there had only been one case

like this reported—of these follicular masses covering the walls of the trachea, I concluded that it was a case of fetid tracheitis. The man was healthy otherwise so far as I could learn.

DR. BLOUNT.—I have had a most interesting case within the past month. I didn't expect to present it until I had completed my treatment somewhat; but as there is nothing before the house I will state the case as far as it has gone. I was sent for to see a woman who was flooding at her menstrual period, loosing a good deal of blood, as her husband told me. I found the patient about, I should judge, thirty-three years of age; and, so far as I could ascertain, the discharge was nothing to give any serious alarm. The case was very interesting to me from the fact that they told me that the woman had been sick for three years, constantly getting worse, never being able to obtain any relief from the treatment of a number of physicians who had seen the woman in that time. She resided in the County near Bridgeton, and had been seen by most all the physicians that practice in that section of the country. She thought she had the dropsy and told me that some of the doctors told her that she was affected with that trouble, and one of them had twice come prepared to tap her. I found her legs somewhat swollen, her abdomen enlarged, extreme tenderness in the abdominal and pelvic viscera. I happened to be the first physician that had made a vaginal examination and that was the means of inspiring great trust and confidence in myself; I was enabled by this means to ascertain that the womb was very tender, irritable and somewhat prolapsed.

Well, I didn't know what was the matter and I spent three weeks in hard study trying to find out. I also took another somewhat eminent physician in this city, out to see the case in consultation and he elicited a statement from the patient that I had not been told; she told him that she passed enormous quantities of water, sometimes she said, as much as two and three gallons. He suspected a case of diabetes, and told me to test for sugar. So that I spent several days in making the tests. I took a number of samples of urine and tested them for sugar, but I was not satisfied with my tests. I got something with the reaction, but I didn't know what it was; I was not satisfied that it was sugar. I took a sample down to the college to Dr. Friedman and had him test for sugar, but he didn't find any. I took another sample to Dr. Kingsley and I tried all the tests,

Frielings, Trommers and More's; then Dr. Kingsley had the kindness to make a microscopical examination of the urine for me, and he found no trace of sugar, but found that the urine was normal in its specific gravity, so I began to doubt the woman's statement that she had passed such large quantities of water, and I had her measure it and found she passed, some days a pint, and some days three pints, according to her statement, the quantity was greater near her menstrual molimen; the quantity varied. I attributed this increased quantity of water to natural causes and nervous trouble. One reason why I suspected diabetes was because the patient complained of an aggravation of her general symptoms after eating starchy food. Well, not finding any sugar in the urine I excluded the theory of diabetes from the diagnosis, and having found that the quantity of water was not excessive I wondered then what was the cause of the dropsy. I had at no time seen the patient when her abdomen was much distended, and when I did see her when her abdomen was slightly distended, I was unable to make out whether there was water there or not. There was considerable fat about the abdomen, and I didn't get as clear a sound as I would expect in a tympanitic patient, nor did I get as dull a sound as I would expect from the presence of water. But not finding any sugar in making our tests I began to suspect that there was no water in the abdomen; I began to suspect that the trouble from the digestion of starchy food was owing to fermentation, and I put my patient upon nox vomica, creosote, and liquor potassa. That is the only treatment I used, with the exception of hot water vaginal injections, which I had ordered when first called, and hot poultices to the abdomen. I had given no internal remedies whatever until I made this diagnosis of fermentation. I saw my patient about four days after I commenced this anti-ferment treatment and she was up and about, and told me that she was better than she had been in two years. I believe I neglected to state that the woman had profuse leucorrhœa. That is as far as my treatment has gone. I have not seen the woman now for four or five days, but the case was very interesting to me from the fact that she had had no physician heretofore who had made anything like a diagnosis, and the one who was going to tap her would have made a great mistake if he had tapped for water and found that he had punctured a bowel; and the fact that I took a rather eminent physician out with me, who had been led astray by the answer of the patient, and who

wanted me to send the patient to a hospital instead of treating her at all. I attributed her nervous symptoms to the displacement of the womb, and the general abdominal tenderness also to this displacement. She had an attack of malaria three years ago, from which time she dated her general sickness. The stomach and bowels are in good order, the bladder is extremely sensitive to the touch. There was no evidence of any cystitis under the microscope; and there was no evidence of any marked kidney trouble, from the examination of the urine.

DR. ATWOOD.—As I have practiced medicine some eighteen or twenty years, I took some interest in the statement of the Doctor. There are two or three physicians living in that section of the country who are really excellent members of the profession. I don't khow whether any of these wanted to tap the woman or not; but I take it from the statement of the case that the woman is hysterical, dependent upon debility. This patient has subacute inflammation of the womb, perhaps endocervicitis. I think all the phenomena presented were dependent upon a derangement of the nervous system, which is called hysteria, which comes in so many forms that it is difficult to say whether it is a mere symptom of disease, or is the disease itself. With regard to the statement about the profuse discharge of urine, I am prepared to believe it. It is one of the phenomena presented in hysteria—the profuse discharge of urine. Sometimes there will be a suppression of urine, that is to say the bladder will not discharge it—it can not be gotten rid of even without the use of the catheter. The Doctor made a vaginal examination and found tenderness about the abdomen, he found œdema of the extremities; I don't see anything very extraordinary in the case, upon his own statement. The treatment in this case, it seems to me, should be to give anti-spasmodics and tonics.

DR. BORCK.—This case is an interesting one. It may be such a case as the Doctor has just announced it to be, but I wish to make this remark and give the case consideration. The question in the Doctor's case would be this: first, there was œdema of the lower extremities, swelling of the abdomen so that a physician once or twice came prepared to tap the woman; she passed large quantities of water; now the question that I want to ask is this: did this œdema of the lower extremities occur before the

swelling of the abdomen, or did it occur after the swelling of the abdomen had been noticed? The next question that I would settle would be this: Is this fluid which has been passed by this lady, urine or is it not urine? That is the question; are you positive that it was passed by the bladder? I would then inquire whether it came from the bladder or whether from the vagina, or whether it might have been passed per rectum. The reason I mention these points is, that I had an interesting case a few weeks ago; a lady under my observation complained of a trouble similar to what the Doctor has stated, and her abdomen was enlarged; she has been advised to be tapped two or three times, but she was not tapped. She went away from home and stayed away for two or three months and returned better. The abdomen was still enlarged, very large, so that her husband and parents and neighbors thought that she was pregnant and certainly must have two or three babies. Another physician was attending this lady at the time I saw her; and at that time her abdomen was not so large as it had been. She said she had passed large quantities of water from time to time and had been examined for all kinds of diseases, and the gentleman who examined her then suspected tumor. Well as I said, she passed large quantities of water from time to time and she couldn't exactly say where the water came from. By the time that I saw the case, there had already presented itself an incipient cancer upon the abdominal wall; it was not clearly distinguishable externally, but there was a tumor there. When I first examined her, I did not examine her with a view of finding a certain disease. I generally prefer to look for a healthy organ; in this case I found that the bladder was healthy. I then looked for the ovaries, expecting to find two healthy ovaries; but I only found one healthy, the second was not healthy; there was evidently a tumor and I could move the tumor. I could feel the tumor through the vagina, but if you want to be sure, you should make the examination per rectum if you cannot satisfy yourself from the vaginal examination. I made this diagnosis: that the lady had ovarian tumor and that the fluid which was passed, was passed from this tumor. We do not have these cases very often, but we do have them, in which the ovarian tumor empties itself per rectum, or perhaps per vagina; in this case it passed per rectum. It passed through a fistulous opening. This was my diagnosis and was verified by the abdominal section. Of course, there might be something else;

there might be cancer connected, may be a dermoid cyst; but at any rate there was an ovarian tumor and it had persisted in spite of all the treatment. Nothing was left to be done in the way of treatment and they consented to abdominal section. I opened the abdomen and found that there was cancer of the abdominal wall, and that it had contracted or grown around the tumor of the ovary, which was about as large as my two hands; the cancerous mass had formed so closely that you could not distinguish by the examination, that there was a cancerous growth before the section. The water which passed from the tumor, passed through a fistulous opening into the rectum. It may be that in some cases the ascetic fluid is mistaken for urine.

DR. POLLAK.—There is so much difference between urine and ascetic fluid that I don't see how a mistake can be made.

DR. BORCK.—I have seen the mistake make.

DR. POLLAK.—The fluid from an ovarian tumor is very albuminous and I don't see how the mistake could be made.

DR. BORCK.—One who is well acquainted with it and careful, who is well acquainted with the fluids of the abdomen, is not likely to make a mistake, but one who is not may be mistaken.

DR. ATWOOD.—The extreme part of Dr. Borck's statement is, in any one supposing it was possible to make a mistake in this case, and suppose ascetic fluid was urine, when it was stated that Dr. Kingsley examined it and Dr. Friedman examined it.

DR. BORCK.—I will state that when one takes fluid that is brought to him and examines that fluid for sugar, tests for sugar only, he may make mistakes. Of course, if the fluid were taken to him and he were asked to examine it and find out if it was healthy urine, then he would examine for all the healthy constituents first; if found normal, exclude all other speculation; if some abnormality is found present, find out what that is and he will not be apt to make a mistake.

DR. BLOUNT.—I first made a test of the urine which gave me something—I dont know what it was, as the urine was some that passed from the woman, what was used afterwards was drawn with a catheter from the bladder. We examined for everything, but sugar was the only thing that was suspected, and in regard to the statement of her being hysterical and pass-

ing large quantities of water I doubt if the woman ever passed much over the normal quantity. What she claimed was not that she was passing large quantities at a time but that it continued all through. I am certain in my own mind that the woman is hysterical, but the hysteria I believe to be due to the displacement, it is also the cause of the leucorrhœa. But I was mostly misled in my diagnosis by the patient telling me what all these other doctors had said was the matter with her.

Dr. Green.—I only want to say to the doctor that the wisest plan to have adopted in the case would have been to pass the catheter into the bladder, first telling the woman not to pass any urine till you came again, holding it back as long as possible. The first thing to do would be to find whether it was urine or not, and then to have ascertained the quantity passed at a time. To have emptied the bladder with the catheter after she had retained the urine as long as possible and see how much was passed. And again if the woman passed gallons of water, as she clamed, the bladder must have deen emptied every few minutes or the bladder must have been overdistended. By introducing the catheter you could have shown at once that this was not the case, and then doctor I think if you had examined the abdomen, both in the vagina and through the abdominal wall you could have determined whether there was any tumor or not, because in case of cancer these women sometimes have great loss of blood.

Dr. Blount.—The anaemia would account for the excessive loss of blood.

Dr. Green.—There may be anaemia without any discharge of blood at all. Then I would like to ask Dr. Borck if this ovarian disease was of a cancerous nature.?

Dr. Borck.—No, sir, it was simply an ovarian cyst.

Dr. Green.—What caused the fistula of the rectum, was it the cancerous affection of the malignant disease of the ovary.?

Dr. Borck.—I told you distinctly that the cancerous affection came later, that this woman suffered three years with this trouble, that this water passed through the rectum before there was any indication of cancer, it was a non malignant opening.

DR. GREEN.—The cause of the fistula was a boring of the tissue.

DR. BORCK.—Yes, sir.

SATURDAY, April 21st., 1883.

DR. FAIRBROTHER.—Mr. President. I will report briefly, a case of phlebitis. Mr. V. B. æt. 30, married, of moderately regular habits and by occupation a ticket agent, came to me about the middle of March past with the general symptoms of fever; not being able to locate definitely the disorder, I prescribed for the symptoms. Two days later I was called to his house and found the fever running extremely high. Although there was a little cough and slight rales in one lung, and some tenderness over the stomach I did not consider either or both of these sufficient to account far the high febrile excitement. This fever continued, notwithstanding active antiphlogistic treatment, for a period of four days, when it gradually subsided. Although during the fever there was complaint of frequent pains in the back and legs, these pains were referred to the bones, and were such as usually accompany fevers; and it was not until the entire disappearance of the fever that the local pain became manifest. This was situated about the middle of the posterior part of the lower leg. Upon examination, the inflamed condition of the internal saphenous was readily detected. At this time the disease was limited to a small section of vein, but it slowly extended upward toward the popliteal space, and finally, upward along the internal thigh until it was lost under Poupart's ligament. There was no redness nor unusual heat of the surface. The only symptoms of inflammation were the pain and the enlarged and hard condition of the vein. The pain was excruciating, and any motion of the leg unbearable. There were occasional rigors followed by fever lasting a day or two. Along the thigh many of the tributaries to the saphenous became involved, and so hard and elevated were they that their course could readily be traced by the eye. For more than a month now this condition, with changing features, has continued. At times there have been symptoms of septic poisoning, and the outcome of the case exceedingly doubtful. The prospects are now favorable. With regard to treatment a variety of courses

have been pursued. The general treatment has been antiphlogistic and tonic. The local treatment has consisted mainly of rest, hot application, rubbing with chloroform liniment, bandaging etc. This is the first case of idiopathic phlebitis that has come under my observation.

Dr. Pollak.—This is indeed an interesting case and a rare one. We often see something similar in puerperal women, for phlegmasia dolens is nothing but phlebitis, but I do not remember ever seeing a case in a man except as a result of traumatism. I would like to ask the doctor if there is any gouty or syphilitic history, and what position of the leg is most comfortable.?

Dr. Fairbrother.—There is no history such as is alluded to. And the most comfortable position is a flexion of forty-five degrees.

Dr. Pollak.—Indeed I do not understand that. It should be otherwise. In phlegmasia dolens it is not so. In this disease the woman insists upon keeping the leg straight and flexing increases the pain. Why should it be different in this case.?

Dr. Dickinson.—It seems to me that this is a case in which massage could be employed with the greatest advantage. I have no confidence in the use of liniments without massage, and it seems to me this is a case that demands such treatment. Liniments may be used in addition. Wherever there is a tender spot that is the place to receive the most friction. The massage should be commenced at the foot, the extreme ramifications of the veins, and should be then carried entirely up to the groin, using such a degree of pressure as the patient can tolerate and not be very painful. It will be found after a few days that the pressure can be increased. I do not speak from absolute experience in this matter, but in those cases of a similar nature where I have employed friction, I have found a very great advantage. Probably the Turkish bath would also be of particular service, but I would rely generally upon friction, or pressure, I may say, along the course of the vein from the foot to the thigh. This may be done for half an hour, may be once or twice a day. I suggested the employment of *massage* for the treatment of chronic phlebitis for the purpose of *expressing* the products of antecedent inflammation from the walls of the affected vessels.

The four essential factors of inflammation are present or *have been* and have left their characteristic sequelæ: 1. Pain is subjective, appreciated only by the patient. 2. Redness, when sufficiently superficial, is perceptible to the eye. 3. Heat, and 4. Swelling are estimated by the sense of feeling.

In this affection the outer and middle layer of the vessel are the parts involved, the internal is not obnoxious to the same morphological conditions. Not being a vascular tissue, and, if at all, is only secondarily affected. The vaso-vasorum are hyperæmic to an intense degree. Stagnation of blood and lymph ensues, conducing to hyperplasia in the walls of the vessels which conveys to the finger the sensation of a cord underlying. Miller has most classically and significantly defined the cause of swelling, viz.: "Extravasation of the vascular contents into the inter-vascular spaces." It is a well-known fact in surgery, that swelling in a superficial part, as the arm or leg, may be perceptibly diminished, and in a short time, by methodically rubbing in the direction of the venous and lymph currents. This is *the form* of massage which on theoretical grounds, I recommend for phlebitis and for the same reasons. Heat with moisture and other topical affections may be employed simultaneuosly and perhaps the most effectual wrapping is the entire portion of the limb in a plaster of ung. hydrarg. Liniments the most composite or cutaneously active, without the intelligent, patient and persistent friction with pressure, will avail comparatively nothing. The degree of pressure and friction by the fingers or hand, must be proportioned to the amount of swelling, degree of tenderness of the part, and profundity of the vessel; but in all cases must be extended and applied in the direction of the venous current. This manipulation should be commenced near as possible to the junction of the affected vessel with that into which it discharges its contents and by degrees lenthening the frictional stroke backward. The contents of the vessel itself may not, in any degree, be involved, for it has been demonstrated that phlebitis may exist and the blood current remain perfectly free and unobstructed.

The *modus operandi* of massage thus employed is entirely mechanical, having for its sole object, the putting in motion that which has become stagnant, or promoting the progress of that which manifests a proclivity to statis; and by this facilitating the introduction of extravasations into the blood currents, secure

its ultimate elimination therefrom by the several emunctories, in the aggregate constituting the process of *absorption*.

I think there is little or no occasion for the apprehension that embolic or thrombolic process will be induced or even favored by the massage thus effectively employed.

Dr. Pollak.—It has benefited a number of people in the city here whom I know; one who was the victim of gout for some time. He was advised to try manual massage, and did so but it did not relieve him; he then used the mechanical massage and it has been of the greatest benefit to him; he now walks with the greatest ease. He called my attention to it and I was perfectly amazed at the results. It acts so rapidly and has so many movements that it is vastly superior to manual massage.

Dr. Watkins.—Dr. Fairbrother has presented truly, a very interesting case. It is a diseased condition that is met with but rarely. Drs. Pollak and Dickinson recommend massage in such cases, or at least suggest it, and that its application shall be made with force. I should deprecate massage for two reasons: 1st. Any structure under inflammatory condition should be kept strictly at rest. 2d. Dr. Fairbrother or any other physician can not to a certainty diagnose or tell the exact condition of this vein, to what extent degeneration or disintegration has taken place, in the lining membrane of the vein, and one of the greatest dangers from phlebitis, namely embolism, might be produced from massage, especially if applied with force, as suggested by Dr. Dickinson. I would feel warranted in treating this affection as I would *phlegmasia alba dolens* of the female. *Rest*, applications of ungt. hydrarg. and the envelopment of the limb entire, in oiled silk. I might give small doses of calomel on general principles, in fact, treat it on the so-called anti-phlogistic plan, but above all, *rest* and no massage.

Dr. Stevens has suggested the question of doubt, held by many, that phlegmasia alba dolens is not a phlebitis. I cannot but consider it certainly a phlebitis, the general constitutional disturbances accompanying the trouble, the tenderness along the course of the vein, all would indicate to me an inflammation of underlying structures.

Dr. Ohmann-Dumesnil.—If the case is one analogous to phlegmasia dolens, I would like to call Dr. Fairbrother's attention to a paper that was read at the last meeting of the State Medical

Society by Dr. Schenck on the application of the rubber bandage. He claims that he has had extraordinary success with it in the treatment of such cases, and certainly if the case mentioned is an analogous one it ought to be equally beneficial; the objects to be attained are increased action, uniform pressure and rest.

DR. POLLAK.—In answer to Dr. Watkins I will say, the analogy between the phlegmasia alba dolens and this case is not exact. Phlegmasia dolens generally begins at Poupart's ligament, owing to the obstruction of the vein; now Dr. Fairbrother states this trouble began below and went up. This is an entirely different thing. I never heard of such a case beginning below and going up. In phlegmasia dolens it is directly the reverse.

DR. JOHNSTON.—I believe the doctrine in regard to phlegmasia dolens is that it is due to a disordered state of the lymphatic glands. German obstetricians still claim that it is due to the absorption of septic matter from the internal portion of the womb; that the womb has come in contact with the air and the recoiling process is going on and there occurs what is termed septic matter, which is taken up and this causes phlegmasia dolens. I have seen some cases of this trouble. In the older works we were taught that we had an inflammation of the vein to deal with. If it was truly an inflammation of the veins and the lymphatics were not involved, we would not have that whitish appearance. The older writers on this subject recommended bleeding, and I still think it good practice in plethoric females, whether it be an affection of the veins or the lymphatics, to reduce the quantity of blood, and thereby affect the circulation in the heart and arteries; and the next practice would have been to give mercury, with the idea of checking the recoiling process. Now in this case it seems that the blood vessels were gorged with blood and stasis had taken place; that the circulation in the vein was perhaps suspended; and if there was inflammation in the vein, then the practical common sense thing to do would be to place the leg in a flexed position, as the gentleman did, and give it rest. Now in regard to massage, if the trouble has passed the active stage of congestion, of stasis, and it requires stimulation, then massage, either with the hand or by the machine that has been imported from New York, would be good practice; but before that time we will only increase the destructive influences that are going on in the vein and perhaps bring about an organic lesion, or as

one gentleman has stated, we might remove a few pus corpuscles in the vein that have partially organized, and these passing along would produce embolism. So that the best plan, in my opinion, would be not to use much violence until the active stage had passed. I should have some hesitancy about bandaging the leg in its active state of inflammation; I should prefer to reduce the inflammation by cold applications. A bandage might answer the purpose, but my observation of the use of the bandage in acute inflammatory condition has been that it gives a good deal of pain. Here I think that quiet and the use of a bandage might do the greatest amount of good, but the difficulty is here; there must have been a cause producing the acute inflammation of the vein; we are bound to assume that there was an irritant which has caused the inflammation not only in the blood of the vein but in the vein itself and in that condition if we attempt too much motion, we increase the irritation. If we put the bandage on too tight, we don't furnish a sufficient amount of nutrition, we interfere with it, and we will have a greater disturbance and death of the parts ensuing; in such a case if we apply the bandage we may do a good deal of harm; but it strikes me, Mr. President, that that would be the most rational treatment. In the absence of the bandage I should think the treatment that is applied in phlegmasia dolens—inflammation of the veins and arteries—might be used with good results; the application of warmth and fomentations. We apply these with the idea of producing a relaxation of the fibres of the lymphatics and also the veins, and by that relaxation, force the heart and capillaries to cause the blood corpuscles to flow on and return to the heart, and thereby carry on a certain amount of nutrition and thus overcome the stasis, and thereby cure the patient by this application. What the remedy in this case would be, I am not prepared to say. I should say that it would be advisable to stimulate the nerves, if we could select the proper remedy to give tonicity and a sufficient force to carry on the circulation; what remedy that would be I don't know.

Dr. Fairbrother.—Electricity?

Dr. Johnston.—In its chronic stage that would be an admirable remedy I should think, but not in the acute stage. I think I would try this India rubber bandage; in several cases in which I have used it I have got good results from its use.

DR. STEVENS.—The subject introduced by Dr. Fairbrother is of interest to me at this time, for the reason that I have within a few days, witnessed a case of this disease. While spending a week in the town of Elkhart, Ind., I was invited to a consultation with Drs. Wear and Latta. The patient was apparently about twenty-two years of age; the labor took place about the 1st of March, and required the use of forceps. At the times of my visit the first stages of the disease had passed, the swelling of the limb—the left one—had disappeared, septicæmia had occurred, as was manifested by purulent expectoration, hectic and abscesses in the iliac region of the right side, and upon the inner surface of the thigh of the same side. All coincided in the opinion that thrombosis had occurred and that emboli and septic inflammation accounted for the general pyemic condition, and for the abscesses in the localities mentioned. It was agreed that incision of the iliac abscess was necessary, but that circumstance justified a delay of a few days. I shall learn further particulars and will report to the society. The patient is in the hands of physicians of experience and skill. The subject of phlegmasia dolens is full of interest, particularly as connected with it are subjects of scientific inquiry now engaging the attention of our sagacious pathologists. Many theories prevail as to the primary cause of the disease, some ascribing it to the metastasis of the lochia, some to the metastasis of the milk (hence milk leg), others to mechanical injuries, pressure, etc., implications of the arteries, veins and lymphatics and nerves in and about the pelvis. Without pretending to any considerable observation or experience, I cannot help being impressed with the idea that very efficient and adaquate causes may exist in injury either to the nerve troubles in the plexuses or to the nervi vasorum supplying the coats of the vessels, thus causing partial paralysis, and secondarily, stasis in their circulation. It appears to me that what is commonly understood by the term phlebitis, does not by any means embrace the conditions. Even in the first or most active manifestations of the disease, there is an absence of many of the ordinary indications of inflammation, the temperature is but slightly elevated, in fact, in many instances it is considerably lowered, the surface, though the limb is swollen, is pale and glistening and becomes very soon partially anæsthetic; the pain being of a dull or heavy character, the part not sensitive to pressure. Whether the primary lesion is to be looked for in the nervous or

the vascular structure, is a question that may remain for a time unsettled, but the dyscrasia which occurrs in secondary stages is unquestioned, and is of itself a matter of interest and importance. The migrations of trombi and the lodgement of their debris as emboli, especially in vital organs is practically the most serious matter of the affection.

Dr. Johnston.—The case reported by Dr. Stevens has some interesting points; but I have some doubt about the trouble having commenced in the left inguinal region low down. Now I have seen quite a number of those cases of inflammation, and gynæcologists use quite a number of terms to express that condition brought on by mechanical injuries during labor. I would not be inclined to think it occurred from an injury received in giving birth to the child because the abscess would be governed by the laws of gravitation and would form in the lowest part of the cavity. The peculiar glistening appearance of the leg, as I said before, is due to lymphatic inflammation; and I think that is the doctrine that gynæcologists now hold, that it is an inflammation of the lymphatics.

Dr. Stevens.—I will state that the abscess was too far down from the vagina to be a case of cellulitis. It was in the vicinity of the antero inferior spinous process of the ilium.

Dr. Lutz.—Mr. Chairman, the dangers that are designated as the possible causes of death in inflammatory conditions of the veins, are embolic pneumonia and pyæmia. I lost a case yesterday of a patient who was suffering from pneumonia, and in my opinion it was a case of embolism. The embolus was carried from the leg to the pulmonary structure. This man was employed in a quarry some 70 or 80 miles down on the Iron Mountain Railroad, and a rock thrown by premature blast fractured the tibia and fibula in perhaps five or six places. The physician who first saw him dressed the fractured leg. It was a compound fracture. The physician dressed the leg and a week afterwards he was sent to the City, I saw him and had him transferred to the Hospital, and after making a thorough examination of his case came to the conclusion that amputation was the only possible chance for recovery. The entire cellular tissue of the leg extending high up over the knee was inflamed. This was about a week after the injury. I amputated the leg. There was no evidence of pulmonary trouble of any kind when I first saw

him. I made a careful examination of both lungs, and there was no evidence of pulmonary trouble for some days afterwards until one morning I went to the hospital and found him breathing heavily, and on percussing the chest I found that the right lung was engorged and a pneumonia developed, for which I account on the theory of embolus, as the hygienic and sanitary surroundings of the hospital are very good. I concluded that the pneumonia was caused by embolism of the pulmonary structures produced by the absorption of pus from the leg; and it occurs to me that in cases of inflammation of the veins, when death occurs through embolus, it is usually embolus of the pulmonary structures. This is based on the anatomical condition, that forced the embolus, whatever may be its size, through the return circulation to the heart, and thence into the pulmonary tissue and there lodged. The danger from embolus in the cerebral structure would be considerably less—really it seems almost impossible that there should be such a result unless we suppose a very small embolus not larger than a blood corpuscle, to be carried by the circulation into the cerebral structures and there cause embolism. How pyæmia would be a cause of death in cases of phlebitis is equally apparent to me, when we remember that the products of the inflammation are located in the parietes of the vessels, and would quite naturally be carried through the circulation and if these products, as is most likely, should have undergone degeneration such as would result in the multiplication of the products of the inflammatory action in the vein, it stands to reason that very soon the life fluid would be poisoned. Now about the treatment in a case of this kind. I believe that rest for the part which is affected with the inflammation is the first indication, and I believe, too, that the application of the hard rubber bandage is of great service. I use this bandage a good deal in inflammations about the extremities, and especially the lower extremities. I think in varicose veins there is no treatment that promises such uniform success, excepting perhaps the obliteration of the veins. I have used it also in angry looking ulcers, deep excavations with cartilaginous edges, white hard edges, and I have seen them heal most rapidly under the use of the hard rubber bandage, and what is more the patient need not necessarily remain in the recumbent position with his foot elevated, but can go about his business.

Dr. Stevens.—I think that the relief which we often see follow the use of hot applications in these cases, is due to its influence upon the nerves, that, at least would be the explanation I would make in my own mind. There is another danger arising from this inflammatory condition of the veins and that is of laceration of the vein. This sometimes occurs. The walls are very resisting sometimes, but in a depressed condition of the system and especially in varicose veins we are called upon to treat laceration of the veins, or rather the hæmorrhage following it, more than the laceration. I remember a case that lately came under my observation in which a strong butcher had varicose veins, and without any apparent cause, except perhaps that he felt for the last few days a sensation of itching in his leg, the vein burst, and I subsequently found a laceration that had extended probably an eight of an inch in diameter along the inner saphenous vein. I used in this case a bandage—a linen hand kerchief bound around it, and over that a tight bandage. I kept the man at rest and left the bandage there until the opening closed. I used no other treatment. Now in acute phlebitis I can explain to myself how gangrene will often take place, and how hæmorrhage might possibly occur, but for the treatment of that, like numerous other conditions of that kind, the tentative treatment—symptomatic, dependent on the condition of your patient, and dependent on what will do the most good, is indicated rather than laying down any specific course of treatment to be followed.

Article LXIII.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

[Reported for the Journal.]

Thursday Evening, April 12, 1883.

Dr. M. O'Hara in the Chair.

Three Cases of Aneurism and a Specimen of Fracture of the Case of the Skull. Presented by Dr. Guy Hinsdale.

Case I.—Aneurism of the Arch of the Aorta.—Wm. G., a fireman, æt. forty-four, was admitted to the Episcopal Hospital, Sept. 16, 1881, suffering from pneumonia of the right side, associated with signs of pleurisy. It was noticed at the time of his admission that there was a slight diastolic murmur heard at the aortic cartilage and that no radical or ulnar pulse could be felt upon the left side.

The pneumonia pursued its course until it ended in death, on the eleventh day after admission. Eighteen hours before death occurred, after an attack of severe pain along the course of the sciatic nerve, he suddenly became unconscious and his respiration, puffing. His pupils were contracted and his left arm rigid. His pulse became at once fuller and stronger than it had been since admission, there being ninety-six beats per minute. Fifteen hours before death the right side of the face was paralyzed. The radical pulse was smaller on the right side than on the left. The right foot was cold and the posterior tibial pulse behind the internal malleolus was just perceptible. Respirations were forty per minute, and stertorous; sweat and urine profuse. Twelve hours before death, respirations fifty-seven; temperature 106°.

The patient remained essentially in this condition until his death. At the post-mortem examination, upon opening the thoracic cavity, the base of the right lung was found in the second stage of pneumonia. There was hypostatic congestion of the left lung. But what at once threw light upon the later feature of the case was the presence of an aneurism of the transverse portion of the arch of the aorta. The specimen shows a symmetrical dilatation of the vessel capable of receiving a large hen's

egg. On examining the brain, clots, probably of embolic origin, were found in the right cerebral hemisphere, thus accounting for the paralysis which had been observed.

CASE. II.—Aneurism of the Right Common and External Iliac Arteries.—Johann B., a farmer, æt. twenty-six, was admitted to the Episcopal Hospital, Oct. 27, 1882. His previous health was good. He denied specific history and his habits were good. He was able to work until one week previous to admission, when he began to have pain in the feet and legs, shooting up the body to the head. His skin was yellowish, his tongue coated; his urine did not contain albumen. There was œdema of the feet and it is worthy of note that this had occurred on the right side, four months before admission. His spleen was apparently enlarged; his lungs presented nothing abnormal. Systolic and diastolic murmurs could be distinctly heard all over the cardiac area, but most clearly at the right second cartilage and transmitted over the left subclavian and carotid vessels. The heart was considerably hypertrophied.

Six weeks later the attacks of pain in the right side, to which he had been subject ever since admission, became more frequent and severe. The murmurs at the aortic valve were systolic and diastolic, low, soft and confused. A distinct thrill was now felt; heart's impulse quick and trembling.

Above one week before death a swelling occurred in the right parotid region, extending to the cheek and lower jaw. Subsequently a discharge thin and purulent, took place from the ear and the patient became unable to protrude his tongue. The œdema of the right leg returned and increased daily extending up to the body, the whole leg being about three times the bulk of the other. The aneurism grew with great rapidity; the distention of the vessel and the overlying structures gave rise to the greatest pain. The patient was unable to lie down and was always found in the sitting posture. The mind was clear up to the day of his death, which occurred two month after admission.

At the autopsy, upon opening the abdomen, the aneurism was found very prominent, occupying the right side of the abdominal cavity and extending from the concavity of the liver to Poupart's ligament, a distance of about nine inches. The aorta bifurcated at the upper border of the fourth lumbar vertebra, the tumor arising from the common iliac artery, one inch from the aorta.

Its whole anterior surface was covered by peritoneum. The right kidney was elevated, lying upon the tumor's upper surface, the ureter passing over the convexity of the tumor and to the inner side. The psoas muscle and crurale nerves were displaced and stretched to the outer side of the aneurism. The femoral artery emerges from the tumor one inch above the origin of the profunda.

Upon opening the sac a second sac was found within. No rupture had taken place. The cavities of both sacs were found filled with clots in various stages of organization. The walls were leathery and large flaps were found attached to them. There were also *post-mortem* coagulations.

The line of the blood current could be determined by the passage of a catheter. This was found both from above and below to skirt the inner side of the tumor and to pass through a comparatively short channel in its interior. Three of the bodies of the lumbar vertebræ were slightly eroded. The heart is hypertrophied; its weight, fifteen ounces. The mitral valve is normal but the aortic valve shows exuberent vegetations which impeded its action and which are very friable.

The specimen presented embraces the heart, the aorta, the aneurism with the right kidney upon its upper surface, the right femoral and the left iliac arteries.

CASE III.—Aneurism of the Abdominal Aorta and left common and External Iliacs.—Mary K., æt. thirty, was admitted to the Episcopal Hospital, Aug. 26, 1882. Her mother died in confinement and her father of heart disease. She had had three children; her husband was a bartender and had been treated for syphilis at a dispensary; but the patient herself denied specific history, nor were any evidences of it found. She had never been ill before.

Seven months previously she had pains in her left groin; these pains extended to the abdomen and about five monhts previous to admission she noticed a small tumor in the hypogastrium, which pulsated and became painful on pressure. Three months later her weight began to fail; she became delicate and lost flesh. For one month the tumor had been prominent. Pain then came on spontaneously at intervals and she had backache. She became weak and took to her bed. Two weeks before admission the left leg and thigh became painful and felt

benumbed, and motion grew difficult and for a time was lost. Meanwhile the tumor increased.

Upon admission she was weak. Her face showed anxiety and suffering and had a pinched and haggard look. Her lungs and heart were normal. On the right side of the abdomen a tumor was felt, one inch above the umbilicus and extending from one inch to two and one-half inches from the median line, downwards two inches. It was painful on pressure, pulsated distinctly and over it a distinct systolic *bruit* could be heard. A distinct notch separated this from a large hard mass in the left iliac fossa, indistinctly pulsating, imovable and not particularly painful on pressure. There was a faint *bruit*.

In the left thigh there was insensibility to touch, over the distribution of the anterior crural nerve, while pain in the left knee was often so great as to deprive her of sleep. The urine did not contain albumen.

At the end of two weeks sensation was diminished on the left side as high as the edge of the ribs and in the whole of the lower extremity, excepting the first and second toes. It was impaired over the buttock. Œdema of both legs occurred. The posterior tibial on the left side could scarcely be felt to pulsate.

Sept 13, the patient suddenly died. At the autopsy the abdomen was first opened. There was no blood in that cavity. Upon the left side in the iliac fossa there was a prominent tumor of the size of a cocoanut; over it lay the psoas muscle which was spread out in the shape of a thin aponeurosis. The iliacus muscle was displaced. The psoas parvus was inserted in the tissue covering the tumor.

A fusiform dilatation of the aorta was then noted. The diameter of the aneurism was three times the normal diameter of the aorta. Commencing from a point seven inches above the bifurcation, it extended downward nearly five inches.

A second aneurism occupied the left iliac fossa involving the left common and external iliac arteries. It was about six inches in length and was filled with old, fibrous, laminated clots. The latter aneurism had opened posteriorly behind the peritoneum and against the iliac bone. There had evidently been ruptures previous to the one which finally caused the patient's death.

There was found old as well as recent clots outside the aneurismal walls. There was no erosion of the bones. The femoral artery was normal and no atheroma or evidences of syphilis

observed, although the woman had been exposed to infection from a syphilitic husband.

Dr. C. M. Wilson presented the following specimens, the notes of which will appear in some future issue, owing to the author's failure to forward the papers to the Recorder: Case of Invagination of the Ileum; Case of Large Vesical Calculus; Case of Multiple Vesical Calculi.

THURSDAY, April 26, 1883.

JAMES TYSON, M. D., President, in the Chair:

A Lecture on the Methodical Examination of the Brain. By Dr. Charles K. Mills.

The lecture was amply illustrated by diagrams and specimens prepared by Dr. Mills, and also by a series of preparations from the *Müeller Museum* of the College of physicians of Philadelphia.

Dr. Mills passed by, with brief allusions, the scalp, skull and membranes of the brain, the cerebral space and vessels, and the best methods of determining volume, specific gravity and cranial capacity. His chief object in the lecture was to discuss and demonstrate the proper proceedures to be pursued in methodically examining the surface and interim of the brain, after the removal of its envelopes, for the purpose of discovering and accurately localizing lesions.

In order to make an autopsy of the brain proper, in a rapid, methodical and scientific manner, he considered several requirements necessary.

1. The superficial topography of the brain should be understood. The examiner should be able to pick out, without hesitation, the chief tissues and convolutions. He should, also of course, be perfectly familiar with the numerous superficial subdivisions of the base of the cerebellum.

2. The variations in the size, direction, or arrangement of cerebral fissures and convolutions most likely to occur, should be known to him. Age, race, individual type, education, and other causes act to produce variations and anomalies. The student thoroughly familiar with the diagrams and the demonstrations of Ecker, might find himself at sea in his first examinations, if this fact is not remembered.

3. A knowledge of the internal structure of the brain should be possessed by the operator. He should understand not only its ventricles and bones, its commissures and peduncles, its foramina and acqueducts, but also its medullated structure, as exhibited by sections of the cerebral and cerebellar hemispheres made in various directions. Methodical cerebrotomy, practiced in the vertico-transverse, vertico-longitudinal, horizontal and even in other directions, will give certain more or less fixed appearances which should be familiar.

The surface of the brain should be thoroughly examined for morphological peculiarities, such as deficiency or excess of fissures and gyri confluence of fissures, simplicity or complexity of folds and furrows; and also, of course, for pathological changes, for atrophy, softening, hæmorrhages, changes of color, etc. Dr. Mills described the fissures and convolutions as given by Ecker, and also called attention to some of the most common and striking variations from the usual type of the adult human brain, dwelling particularly on the fissures most likely to be confused—the precentral, central, and retrocentral, etc. The views and observations of Mary Benedikt on the brains of animals, were referred to, and criticised.

The examination of the fissures, convolutions, cranial nerves and various regions of the surface of the cerebrum and cerebellum having been completed, the interior of the brain should next claim attention. The examination should be made in such way as to cause as little disturbance as possible of the relations of the parts by the incisions, and to allow, if desired, that the brain be brought together again after the autopsy, and preserved as a whole. This could be done so as to submit every cavity, canal, part and structure to comparatively minute exploration. Some cerebrotomists, as Bitot, without stopping to investigate, particularly, into the various cavities and subdivisions, at once proceed to divide the brain into blocks by large incisions made at carefully selected points.

The advantage of each of the three forms of sections—vertical, transverse, vertical antero-posterior and horizontal, were pointed out. The vertical transverse sections are the most generally useful. What are known as the middle transverse, mesolobar, or cortico-central zones, are most important to understand. These comprise all the cerebral mass situated between the anterior and posterior extremities of the corpus callosum. Bitot de-

scribes and figures seven of these zones. Sections and diagrams were exhibited by Dr. Mills, and the places and methods of making the sections were explained.

The particular convolutions, and the regions of the ganglia, centrum, ovale, capsules, etc., transversed by these sections, were shown. The ganglio-insular region was particularly described. This region includes a large portion of the island of Reil, of the optic and striate ganglia, of the external and internal capsules, and of the external wall. The importance of having at command a fixed nomenclature for the various planes and regions was dwelt upon. Following the method of Bitot, the surfaces exposed by the sections were divided into a superior, inferior and middle division, and these were studied. A diagram representing the relation of the middle portion of the brain to cranium was shown and explained.

Dr. Mills said that he preferred to open the brain so as to expose its ventricles, horns and parts, and examine each as nearly as possible in its integrity. By his methods such structures as the corpus callosum, septum lucidum, tænia, semicircularies, velum interpositum, choroid plexus, fornix, foramen of Munro, pineal gland and its peduncles, etc., could be each in turn investigated for lesions.

After the cavities and horns had been exposed by proper incisions, methodical cerebrotomy, as advised by Charcot and Pitre, or Bitot, could be practiced, the cuts being made from within outwards, but not quite through the brain, so that the whole mass could be drawn together again after the cut surface had been examined.

Dr. Mills described three of the best methods of opening the brain.

1. At the base, by taking as guides, certain fissures and other anatomical landmarks.

2. From the upper surface by incisions through each side of the corpus callosum, or along the lower borders of the calloso-marginal fissures.

3. By dividing the brain into two symmetrical halves by a careful median section. This should only be done after the parts in the median line had been previously explored. Dr. Shakespeare said that he would like the lecturer to state why he prefers to open the brain from the base rather than from

above. Dr. Shakespeare thought that by by opening from above the floor of the lateral ventricles would be better exposed, which contain the large ganglia of the brain, and a better topographical view would be obtained.

The most usual cause for which the brain is examined is apoplexy. In these examinations it is very necessary that very thin sections shall be made, so that all parts can be carefull examined. Dr. Mills has already pointed out the desirability of making these sections in such a manner that none shall be detached, so that when the examination is over all can be readily replaced, still leaving the brain practically in one piece. I believe that these two objects can better be obtained by making examination from above, as taught by Prof. Orth (Copendium der Pathologisch Anatomischen Diagnostik) than by making it from below. The only part capable of holdingthe sections together is the cortex with its adherent vessels. Prof. Orth advises making a longitudinal section toward the cortex on a level with the corpus callosum. The section is made deep enough to cut the cortical convolutions half through. This leaves enough tissue to keep the part attached. The anterior horn, the ventricles and posterior horn are laid open by a second incission. Transverse cuts, as thin as desired, are then made in the side pieces. These cuts go half way through the center. The large ganglia are then sliced transversely, beginning at the front and going backward. These are also made to go half way through the corticle substance of the base, and so on. The examination being finished, the parts can all be folded together like the leaves of a book, not a single piece having been detached. The only way I can see of making thin sections of every part by the other method is to divide into two lateral halves, and then making your sections toward the cortex, for if the sections be made directly across the brain, the parts in front of the corpus callosum and behind the peduncles, will been tirely detached.

Another objection is that seven sections are two few, and if it is desired to have more, it will be a difficult task to hold the already cut sections in one hand, and split them with the knife held in the other.

Dr. Bartholow preferrred to open the brain from above for similar reasons to those assigned by Dr. Shakespeare. Dr. Eskridge expressed a preference for the older method.

Dr. Mills then closed the debate by reiterating and emphasizing the arguments contained in his paper.

C. B. Nancrede, Recorder.

Reports on Recent Progress in Medicine.

Article LXIV.

A Fibro-Cystic Tumor of the Uterus.—Laparotomy.—Removal of the Tumor with Recovery. By Reynold W. Wilcox, A. M., M. D., Assistant House-Surgeon, Woman's Hospital in the State of New York.

Reported for the Journal.

While ovariotomy has become recognized by all modern surgeons a judicious proceedure, laparotomy for the removal of tumors originating from the uterus, still occupies the position that the former once had. Yet the increasing number of successful cases recorded that one meets in the journals, bears testimony that the time is not far distant when the surgeon finds during his operation the tumor to be uterine instead of ovarian, he will not be appalled, but will proceed with as much assurance as though his diagnosis had been correct.

So every reported case adds its testimony and increases the confidence of those working in this special field.

The following case will illustrate what may be sought for as an ideal result, the difficulties in diagnosis and the apparent contradiction or history and orthological examination. Those operators who manifest great anxiety that their percentage of recoveries shall be the largest possible and who refuse to operate on all cases that carry with themselves indications of unusual difficulty or having commenced, fail to finish the operation that it may not have a place in their list of completed operations, do not operate for the good of the patient. While Dr. Thomas realizes that at the present time that the cases of removal of uterine tumor do not have so large a *per centum* of recoveries, as those of ovarian tumors, his sense of justice will not allow him to deny to the patient her only hope of recovery. Even operating on unselected cases, the writer feels positive that the statistics will bear favorable comparison with those of any similar institution.

The patient, Mrs. A. P., was admitted to the Woman's Hospital on the 23d of October, 1882, with the following history: A native of the United States, she is sixty-three years old and has been married forty-two years, and is the mother of two children. Her labors at the ages of twenty-two and thirty-nine, were entirely normal. She began to menstruate at sixteen and continued regular in time, duration and quantity until she reached the menopause at the age of fifty, without a symptom of any kind. About eighteen months previous to admission she noticed an indistinct enlargement of the abdomen, which of late has increased slowly. Her only symptom referable to her disease was pain through the pelvis after walking; she has never had any hæmorrhage from the genital organs. About twenty-five years ago she had a watery discharge from the vagina, leucorrhœic in character but which she attributed to impaired health and which soon ceased; no symptoms referable to the bladder. Bowels constipated. Some swelling of the lower extremities. General health good, appetite always good, sleep excellent until four years ago when it became disturbed because of family bereavement. Dyspnœa absent. Palpitation and dyspepsia about five years ago but now wanting. Has lost some flesh. Is now wearing an abdominal supporter.

Physical examination: A mass was found filling the pelvis, both flanks and reaching to the umbilicus. Over the whole of the abdomen below the umbilicus there was flabbiness on percussion. No fluctuation was detected. The uterus admitted the sound to the depth of two inches, was fixed in a position of slight anteversion and deviated to the left. The pelvis was filled by the mass but it was not fixed in it.

Nov. 9th, 3 P. M. The following measurements were taken: Circumference at level of umbilicus, thirty-eight inches; right anterior superior spine of the ilium to the umbilicus, eight and one-half inches; left anterior superior spine, of the ilium to the umbilicus, nine inches; symphysis pubis to the umbilicus, nine inches; tip of the ensiform cartilage to the umbilicus, seven and one-half inches. The patient being etherized, an incision six inches long was made from the umbilicus downwards in the *linea alba*. The peritoneum being opened on a director, the smooth shining surface of the tumor appeared. A small cyst was recognized in the upper part of the tumor and a trocar plunged into it evacuated only a small amount of straw colored fluid. The incision was then prolonged upward and about an inch to the left of the umbilicus, and after some manipulation the tumor was drawn out of the wound. The omentum adherent to the upper anterior surface ofthe tumor was tied *en masse*, and cut off. The pedicle was thick and strong and proved to be the uterus and broad ligaments, the tumor growing from the left side of the uterus. The pedicle was transfixed with a Peaslee needle and a strong silk ligature being passed was tied in the usual way.

The tumor then being removed, there were several small spouting vessels seen in the stump and these were separately tied; the whole stump was then caught in a small Thomas clamp, a strong ligature being tied below this for additional security against hæmorrhage. The wound was closed with interrupted sutures of silver wire, the stump enclosed in the clamp, propounding from the lower angle of the wound. The stump was touched with pure carbolic acid and an antiseptic dressing applied. Spray used in room during the operation. Weight of the tumor, twelve pounds.

Fourth day after the operation. The patient has not developed a single untoward symptom; has a rather troublesome cough accompanied by expectoration of a very tenaceous mucus which at times in difficult to expel from the fauces and trachea. The temperature has not risen above 100°.2 Fahr. and the coil* has been used but little and then only but a short time. Sleep has been good and she has taken nourishment well, in short, has done well, in every respect.

Seventh day. Temperature rose to 101°.4 Fahr., presumable on account of the sloughing of the stump. The coil was kept on the abdomen as well as another upon the head. Did not feel comfortable and face was hot, dry and flush. Food not well taken although no vomiting.

Eighth day. Temperature has fallen to 100°.2 Fahr. with improvement in sleep and appetite. Coil still used. Nourishment chiefly by ordinary enemata composed of beef juice two ounces, brandy one drachm, quinine ten grains, aromatic sulphuric acid ten drops, and compound liquor of opium thirty drops.

Ninth Day. Temperature 99°.4 Fahr. and is feeling much better. Clamp has separated and stump is doing well. On movement patient is rather weak and inclined to faintness.

Tenth day. Doing well, stitches removed and considerable irritation caused by them was found near the stump. Stump is not granulating as yet, as all sloughing tissue has not yet come away. Wound dressed with balsam of Peru.

Sixteenth day. A number of deep sloughs were removed from stump, leaving a clean granulating surface; the remaining portion of the wound is healed.

Twenty-second day. The surface presented by the stump has become superficial. Patient is sitting up.

Twenty-sixth day. An abscess which has been forming in the right natis discharged quite freely to-day. Wound in the abdomen is nearly healed.

Twenty-ninth day. The patient is sitting up every day.

On the forty-ninth day the patient was discharged cured.

The following is the report of the pathologist: The tumor is

* The coil is an apparatus constructed on the same principle as the Leiter Heat Regulator, but of rubber tubing.

a large interstitial myo-fibroma of the uterus. The great mass of the tumor is solid. In the upper part there is, however, a cyst of moderate size. This cyst presents the usual characters of fibro-cysts. The walls are irregular and shaggy, without epithelial lining. The adjacent tissue has undergone some fatter degeneration, this giving it a yellowish collor. About the cyst are brownish and red patches, indicating old and recent hæmorrhages. The veins in the neighborhood of the cyst are in some places filled with dark red thrombi. A few small œdematous patches can be detected in the upper part of the tumor. Torn out portions of these patches bring into view, under the microscope, a number of flat, polygonal endothelial cells, which are joined together. The microscope shows the structure to be myo-fibroma, there being smooth muscular fibres mingled with fibrous tissue. Large veins run over the surface of the tumor, which is everywhere covered with smooth glistening epithelium except where the tumor is amputated. A bit of omentum is adherent to the upper part of the tumor. The general shape of the new growth resembles that of a pregnant uterus. Between the peritoneum and the new growth can be demonstrated a layar of the muscular cord of the uterus about one centimetre in thickness, near the lower part of the tumor and only one or two millimetres at the upper part. None of the uterine cavity is found connected with the tumor.

The fluid removed from the cyst is of straw yellow color, slightly alkaline in reaction and coagulates spontaneously on exposureto the air. The sediment consists of blood globules but no cellular elements.

In making the diagnosis we are to consider ovarian tumor, myo-fibromatous and fibro-cystic tumors of the uterus, as well as sarcomatous tumors of the same organ. For a strict diagnosis by exclusion, all tumors of the pelvis and abdomen as well as pregnancy could be considered, but the four above mentioned cover all the ground that is brought into debate in this instance. For the diagnosis of ovarian tumor we have the situation of the mass to the left of the median line, as shown by the measurements. The hardness and smooth surface of which suggests a fibroma and from the deviation of the uterus to the left suggests that there are adhesion between the mass and that organ. Still in accordance with this idea is the fact that the mass was not tender and the uterine cavity was not increased, yet the size to which the mass had attained, the rapidity of its growth, the fact that the distance from the pubes to the umbilicus was too great in comparison with that from the umbilicus to the ensiform cartilage, render the probabilities in favor of the uterus at the point

of origin, this being shown conclusively by the operation. Yet even with the tumor on the table, the diagnosis may be difficult to establish as it is shown in the case reported by Barker,[1] when after conflicting opinions, the pathologist decided the tumors to be uterine in origin.

A pure fibro-myoma, originating after the menopause, unaccompanied by hæmorrhage, is improbable. Boones[2] says "I do know that it has ever been satisfactorily made out that fibroid tumors originate after the climacteric." *A priori* one does not expect that the uterus in its period of inactivity to be the starting point of a tumor, while it is possible that it may have existed for years unsuspected, at the same time we know of no exciting cause for its sudden and rapid development. Emmet[3] found, of two hundred and twenty cases of fibroid tumors, five consulted him between the age so fifty-five and sixtyyears. That pain other than that due to mechanical causes, was absent, is well explained by Bövuer[4] who says that subserous fibroids do not cause pain other than that due to the peritonitis which they excite, with a pedicle usually one finds ascites. The absence of hæmorrhage is explained by the same author, on the same ground that subserous tumors, in that respect follow ovarian instead of intra-uterine tumors.

The diagnosis of fibro-cystic tumors of the uterus appears to be the most probable, but against this view is the rapid growth which was so characteristic in this case. That this is not without precedent is shown by Hakes' case[5] which filled the abdomen in seventeen months. Fletcher[6] in one year and that of Peau[7] still more rapid, which attained the same size in six months. The age of the patient, also, is unusual, although two cases of advanced age are on record; the first reported by Keith,[8] of a single woman fifty-two years, operation and recovery; the second by Spencer Wells, a married woman of sixty-two, operation, while Peau[9] believes that these tumors originate, by preference, toward the menopause.

In regard to the spontaneous coagulation of the fluid on exposure to the air, pronounced pathognomia by Atlee,[10] Spencer Wells, quoted by Fehling U. Leopold[11] claims to have seen such coagulations in fluid from an ovarian cyst, while in seventy cases collected by Heer,[12] marked coagulation was found in only eleven. Not yet was there any "doughy feel" insisted on by Beatty.[13] Routh[14] believes that fibro-cyst rarely give rise

to hæmorrhage because the majority of them are subserous and so do not influence the uterine mucous membrane.

The rapid growth of the mass, even after comparing it with similar cases, leads one to consider tumors of a malignant nature. The absence of pain and of offensive discharge, considering the length of time, would render carcinoma improbable and it is readily excluded by the report of the pathologist. That it is not uncommonly associated with fibroid tumors, is shown by Arnold[15] who found among fifty-seven *post-mortem* examinations in cases of death from cancer, fibroid tumors occupied the remaining portion of the uterus in four cases. Gusserns[16] believes that a tumor takes on rapid growth in the years of the climatric, when we do not expect a fibroid to increase, we are to consider a sarcoma as probable. To Dr. Thomas[17] belongs the credit of first pointing out that such tumors are by no means as rare as they were supposed, and of first giving a full description. It was to this source that Simpson owes his attention being attracted to the subject.

Two prominent symptoms of sarcoma are wanting, namely, hæmorrhage and watery flood. Pain, according to Simpson[18] is not usual, yet Gusserns[19] says pain is the first symptom of all, and further, a malignant tumor in the fundus of the uterus is probably a sarcoma. In Simpson's cases all approached or had passed the menopause, the oldest being seventy-two; the prominent symptoms being marked hæmorrhage, leucorrhœa, at first odorless and later offensive. He believes that it may develop in in a woman who has had children, but its presence prevents reproduction. The case reported by Terrier[20] is quite in point, a woman of forty-four, had two children, regular catamenia, tumor of five months' duration. Laparotamy was executed and a cystic-fibro-sarcomatous tumor of the uterus was removed, weighing three hundred and fifty grammes, resulting in recovery. Here pathologically[21] the tumor was sarcomatous, and the cyst developed from a hæmorrhagic spot.

Tait[22] says, "whether the sarcomatous tumors of the uterus do or do not arise from perversion of the growth of the muscular fibre, I am not prepared to say but I have seen one on which the cells were so nearly matured into an appearance and arrangement so mearly resembles normal uterine tissue that had it been encephaloid, œdema, can say it was nearly a soft myoma."

In the cases collected by Gusserns[23] sixty-two in number,

twelve were between fifty and sixty, two between sixty and seventy years old, and one had passed the latter age. When one considers that for many years tumors approaching were more sarcomatous than fibrous tumors, in their clinical history, passed under the designation of "recurrent fibroids" and further that fibroids themselves, even of considerable size, have been known to take a sarcomatous degeneration; one can see that the diagnosis is by no means easy to establish.

Maury[24] has given some statistics of laparotomy for removal of fibro-cystic tumors, as follows:

1843-63, fourteen operations with twenty-eight and one-half per cent. of recoveries; 1863–73, forty-two operations, with thirty and nine-tenths per cent. of recoveries; 1873–80, nineteen operations with the per cent. of recoveries reaching sixty-eight and one-half per cent. Certainly this is by no means a discouraging outbreak when one considers the gravity the prognosis[25] and how prone these new growths are to undergo suppuration.

In this connection an unique case reported by Williams[26] of a single woman of thirty-two, with pain in back, prolapse of rectum, agony during and after defæcation. The diagnosis of fibro-cystic tumor of the uterus was made and under chloroform a red hot iron the size of a crow's quill was passed into the tumor through the speculum; some clear fluid was obtained which coagulated on exposure to air, and recovery with disappearance of the tumor resulted. The diagnosis is not conclusive considering the number of tumors one finds in and about the uterus. Certainly the result was far better than in other cases that have been punctured, when ten out of eleven died.[27]

Keith[28] says that while the operation is not to be lightly andertaken, "I hope that the time is not far distant when many of these unfortunates will look to surgery for relief with as much confidence as those afflicted with ovarian diseases now do."

If men who have reputations as skillful ovariotomists, would undertake these operations with the same certainty as they now do ovariotomy, one can believe that the operation will appear less and less formidable as the years go on.

New York, March, 1883.

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2. Diseases of Women, Philadelhpia, 1878, p. 641.

3. Principles and Practice of Gynæcology, Philadelphia, 1880, p. 529.
4. Volkmann Vorbräge, Leipzig, 1882, No. 202.
5. British Medical Journal, Feb., 1883, p. 225.
6. British Medical Journal, Nov. 1882, p. 469.
7. Peau et Urdy, Histerotomie, Paris, 1873.
8. London Lancet, May 15, 1875, *op. cit.*, p. 101.
9. Diagnosis of Ovarian Tumors, Philadelphia, 1873, p. 289.
10. Archiv. für Gynæcologie, Bd. VII., 1875, s. 531.
11. Ueber Fibrocystens des Uterus Zürich, 1874.
12. British Medical Journal, Nov., 1871. p. 517.
13. Transactions Obstetrical Society, London, Vol. VII., p. 202.
14. Transactions Pathological Society, London. 1870, p. 281.
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16. Diseases of Women, Philadelphia, 1880, "Sarcoma and Adenoma of the Uterus."
17. Obstetrical Journal of Great Britain, Feb., 1876, p. 757.
18. *Op. cit.*
19. Review de Chirurgie, Mai, 1881, p. 402.
20. L'Union Medicale, Juin, 1881, p. 1022.
21. Diseases of Women, New York, 1879, p. 104.
22. *Op. cit.*, s. 150.
23. New York Medical Journal, April, 1880, p. 344.
24. DeSinéty Mon. Prubique de Gynæcologie, Paris, 1876, p. 413.
25. British Medical Journal, March, 1881, p. 384.
26. Leopold u Febling, *loco cit.*
27. *Loco cit.*

Clinical Reports from Private Practice.

Article LXV.

Resume of the Case of Mrs. E—. of Elkhart, Indiana. By W. A. Neal, M. D., referred to by Dr. Stevens in proceedings of St. Lous Medical Society, April 21st., 1883. Reported for the Journal.

February 19th, 1883, about 10 A. M., was called by Dr. Eckelman to come and help him in the delivery of Mrs. C., primipara age nineteen and to bring forceps found she had been in active labor for 22 hours the cervix fully dilated and out of the way, that she had antero posterior contraction and was informed that there had been no advance for twelve hours, presentation left occipito acetabular, applied forceps [Bedfords] after slight traction and manipulation there some rotation with a very little advance; then for about an hour in spite of as extraordinary expulsive efforts on the part of the patient as I ever saw and with what traction and assistance I thought was justified (endeavoring to make traction in line of pelvic axis) there was no advance. I then removed and reapplied the blades which could only be placed as before in oblique position the male blade towards left acetabular the female right illiac region, in a short time the childs head began to rotate and advance and I informed the friends that rupture of the pernieum was unavoidable, in another half hour, one and a half hour after forceps were applied, delivery was affected twentyfour hours in labor. I never met with a patient that made as vigorous and powerful expulsive effort, the perineum was torn to, not through, the splimeter, the next day I took three silver wire suteres, which I removed in eight days, all held, and the union was good, for the first eight days she was not under my care, but after that time I was requested to take charge of the case, she was then tympanitic, with impeded respiration, pain over her whole abdomen, more especially in right illiac region, no antisceptic precautions had been taken in regard to injections etc. Her temperature was 102° morn-

ing 104° evening, pulse 116 to 130, I treated her mostly with opium quinine, with two or three quarts of milk daily, when after about ten days pain and tympanitis began to subside her pulse and temperature dropped to 100, and I thought she was going to convalesce, but she was suddenly seized with pain and swelling in the calf of her left leg, which soon involved the whole limb, with temperture 103, pulse 120, or 130°, and I had phlegmasia dolen to deal with, this was treated with tonics, rubefacients, muffling and anodynes, after about fourteen days more, pain and swelling in this left leg subsided, pulse and temperture dropped to 100 or under. Again she was taken with a severe chill and nervous prostration, temperature 105, pulse 140, complete loss of appetite, nausea and vomiting, hurried respiration, anxious expression, symptoms of septic infection, treated mostly with stimulants, and as soon as borne, added food [she used 36 bottles of champagne] after about five or six days she commenced to cough, had flushed cheeks, rapid breathing and "raised a good deal" after about 10 or 15 days of this, she was taken again with pain, again in the right illiacus, just above the illiac bone, [as seen by Dr. C. W. Stevens.] which appeared for a week or more as though it was going to point, but an offensive vaginal discharge commenced, the pain and tumefaction passed down the outside and back of the right leg, (thigh) and settled for a week or so, some two inches above the popliteal space and appeared to me like it might point and form an abscess there, but the pain and soreness at this point got better, and the ankle, foot and calf of the same right leg became stiff, tumid, and painful, and after a week or so of this, her appetite, which had been fair this far, so that she was fairly nourished, failed her, she was nauseated, loathed food, vomited a few times, bowels constipated, had headache, but only slight raise in temperature 96° to 101° pulse 88 to 100, acting somewhat as our malarial remittants do, at the same time the pain and tumefaction of the right limb began to diminish, this has been going on now [May 1st,] about five days, and is the 72nd, day since confinement, she has now but little appetite, bowels constipated, daily rise in temperature of one to two degrees, and of pulse 8 to 12, tongue during the fever red, in remission normal, when she is almost like a well person she has occasional headache. I have faith that the case is now going to soon convalesce but I fear future trouble with the lymphatic vessels of her lower limbs.

Editorial.

Article LXVI.

We notice that Dr. Henry Morton has changed his opinion in regard to water gas being so poisonous, on account of it containing so much carbolic oxide, and so we desire to correct the impression that the statemeat in our last Journal was the opinion of Dr. Morton at present, as he, since he first published that statement, has changed his opinion.

Although the field of journalism is full to overflowing, yet there is always room for a good journal, and as such we welcome the *American Psychological Journal.* Issued by the National Association for the Protection of the Insane and the Prevention of Insanity, quarterly. Edited by Joseph Parrish, M. D., Burlington, New Jersey, with a good core of associate editors. Published by P. Blakiston, Son & Co., Philadelphia. $2 per annum.

News Items.

Article LXVII.

Eratta.—P. 478, May No. 6th line of second paragraph should read "Through the Hepatic vein" instead of. "to the portal vein."

Dr. Edward Borck, of this city, just returned from a trip to Hutchinson, Kas., where he performed ovariotomy upon the sister-in-law of Dr. N. T. P. Robertson, a prominent physician of that place. The patient's home is Fairburg, Ill. She is 63 years old, and traveled, accompanied by her husband, who is 83 years of age, and her family physician, Dr. S. M. Barnes, a distance of over 700 miles, to receive the advice and attention of her brother-in-law, in whose judgment she has great confidence. He selected Dr. Borck to perform the operation, who promptly answered the call, 500 miles away. The operation was performed on the 24th of May, assisted by Drs. Robertson, Barnes and Smalt, all eminent surgeons, and several others. The particulars of this interesting case will be reported by Dr. Robertson for the Journal.

Costly Compliments.—"If a doctor says "goodday," to you, it costs you one dollar; but when a lawyer says "good night," you will find that it has cost you half your fortune.

Falsification of Quinine.—It has lately been discovered by the authorities of the hospitals of Paris, that for some time past the boxes of quinine supplied to public institutions have contained quinine at the orifice and center of the boxes, while the remainder consisted of sulphate of cinchonidine. At first the French papers accused the German and Italian manufacturers of the fraud. But it was soon shown that a patriotic Frenchman was at the bottom of it. The papers were compelled to retract their statements.

THE difference between a druggist and a farm hand is said, by our exchanges, to be, that one is a pharmacist and the other a farm-assist.

TREATMENT OF CHANCRE WITH PYROGALLIC ACID.—At the meeting of the Académie de Médicine of Paris, held January 2, 1883, M. Vidal advocated the employment of an ointment of pyrogallic acid, 10 or 20 parts to 80 parts of fresh vaseline, in the treatment of phagedenic chancres. Starch may be substituted for the vaseline when it is desired to apply the dressing in the form of a powder.

Under this treatment the ulceration is rapidly arrested, and the chancre takes on a healthy appearance; it is quite as efficacious as the cautery, and only causes burning for a few moments. The dressing should be applied twice daily; both the wound and the skin become black in appearance; the virulence of the sore is destroyed in about three days, and this treatment should be discontinued when granulations appear, and the powder of subcarbonate of iron then applied.

M. Vidal states that absorption only occurs to a limited extent when pyrogallic acid is brought in contact with the subcutaneous cellular tissue; its presence in the urine can be determined by the addition of perchloride of iron.—[*Jour. de Méd. de Paris.*

INFLUENCE OF FOWLER'S SOLUTION UPON THE HÆMOGLOBIN IN THE BLOOD.—From an investigation made to determine the effects of the medicinal administration of some remedies upon the proportion of hæmoglobin in the blood, Dr. Fenoglio, of Turin, concludes that the iron preparations vary considerably in their effects; Fowler's solution increases the hæmoglobin, and this becomes more marked the longer it is given. In spite of the general opinion to the contrary, the administration of Fowler's solution is indicated in anæmia, chlorsis, and in general in all conditions in which there is a decrase in the hæmoglobin, for the influence of this agent is very evident in increasing the proportion of the hæmoglobin; and, furthermore, its use increases the appetite and produces a general improvement in the bodily appearance and condition.—[*Medizin. Jahrbücher*, 1882, H. iv.

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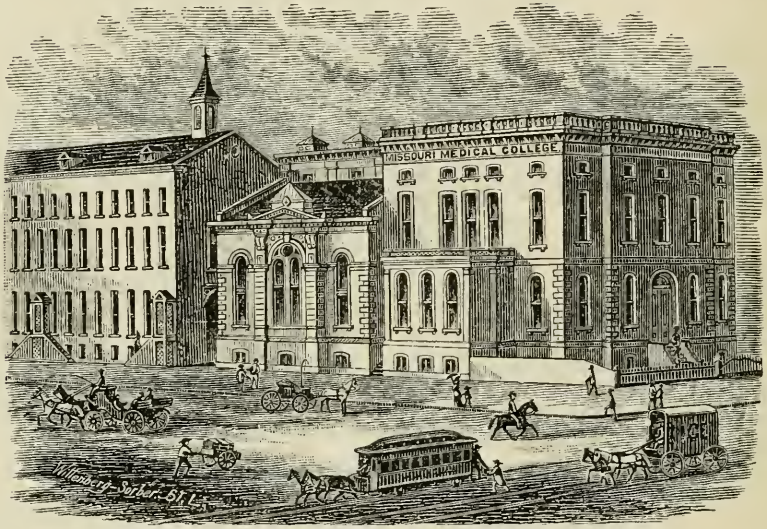

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SAMPLES SENT FREE. SOLD BY ALL DRUGGISTS.

Specify "PLANTEN'S CAPSULES" on All Orders.

We have, also, Capsules adapted for giving medicines to Horses, Cattle, 2 sizes (Ounce and Half-Ounce), for liquids or solids.

VAGINAL & CAPSULES for Mechanical Purposes.

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Do you wish to advertise to the amount of a few dollars only? Apply to us and we will inform you how you can invest the amount most judiciously.

WE WILL TELL YOU HOW.

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Do you wish to advertise extensively? Send a concise statement of what you wish to do, and await our estimation before giving out the order.

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Is your credit so well established that you can secure very low rates by trading direct with publishers? If so, we want your business and will procure you equally low rates.

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If you do much or little, we shall be glad to do it for you, and give you every advantage which our experience of seventeen years enables us to offer.

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Do you find it difficult to get exactly what you want? Write us in detail just what you require and see if we do not give you satisfaction.

AND MORE PROMPTLY,

Are you annoyed by needless delays? We promise you they shall not occur if you trade with us. We always send out all orders and check all papers the day they are received.

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If you want the most expensive advertising, we can give you the papers to do it in. If you want the cheapest, we can do the same and in either case it will pay you to write to us.

GEO. P. ROWELL & CO.,

If you live here or come to our city, we shall be glad to have you call at our offices, whether you are ready to advertise or not.

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We have an entire building of our own; we keep all the newspapers on file and shall take pleasure in showing you how we do our work. If you can't come, write for our circular and catalogue, which will be sent free.

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The Saint Louis
Medical and Surgical Journal.

[Established 1843.]

112 Pages each Issue. **$3.00 per Annum.**

This is the Oldest and Largest Medical Journal for $3.00 in the United States, and it has a more prominent and larger circulation than any two Medical Journals of the Regular Profession in the West, making it the Leading and Representative Medical Periodical in this part of the Country. It is now, and has been for five years, the official Organ of the St. Louis Medical Society. The Proceedings of this Society are so valuable that I insert from 48 to 56 pages each issue. The views represented, are the very latest and the most important to the general practitioner.

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☞Also by dealears in Surgical Instruments generally.

CARD TO PHYSICIANS.

No Physician who has in his practice witnessed the beneficial results of the use of RIDGE'S FOOD, will be influenced in the slightest degree by the adverse so-called "microscopical test" arguments recently published in the several medical journals. And we respectfully call the attention of those who, unacquainted practically with its value, might be so influenced, to a recent article by Prof. Jos. G. Richardson, of the University of Pennsylvania, in the Philadelphia Medical News of June 24th, in which he shows those so-called "tests" to be a series of egregious blunders, devoid of serious consideration by any intelligent physician. Confidently leaving its scientific vindication to those really fitted by scholarship and experiment, the manufacturer of Ridge's Food simply claims—

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3d. That the Food is acceptable to the most irritable stomach when used —as in some cases it must be—without milk, and that it will alone support life.

4th. That it is the best daily food for infants and young children, especially those who are growing.

5th. That it makes the best gruel for a nursing woman.

And finally, to use the exact language of a distinguished American medical Professor, **"The best of all is** *that it PROVES IN PRACTICE ALL THAT IT PROMISES IN THEORY."*

Respectfully, *WOOLRICH & CO., Manuf'rs, Palmer, Mass.*

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MANUFACTURES BY HIS IMPROVED METHOD

SACCARATED PEPSIN, which has proven its superiority over other Pepsins by its stability, uniformity and agreeable taste. In digestive power it corresponds to the standard adopted by the Committee on the 6th Revision of the U. S. Pharmacopœia which is as follows:

One part dissolved in 500 parts of water, acidulated with 7.5 parts of hydrochloric acid, should digest at least 50 parts of hard-boiled Egg Albumen in 5 to 6 hours at 100° to 104° F.

DRY PEPSIN CONCENTRATED, particularly recommended to manufacturers, possesses 8 times the strength of the above.

PREMIUMS were awarded to the above preparations at the international Exhibition Vienna, in 1873, and the Centennial Exposition in Philadelphia.

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Contains **THE ESSENTIAL ELEMENTS** to the Animal Organization—Potash and Lime;

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And the **VITALIZING CONSTITUENT**—Phosphorus,
Combined in the form of a Syrup, with *slight alkaline reaction.*

IT DIFFERS IN EFFECT FROM ALL OTHERS, being pleasant to taste, acceptable to the stomach, and harmless under prolonged use.

IT HAS SUSTAINED A HIGH REPUTATION in America and England for efficiency in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs, and is employed also in various nervous and debilitating diseases with success.

ITS CURATIVE PROPERTIES are largely attributable to Stimulant, Tonic, and Nutritive qualities, whereby the various organic functions are recruited.

IN CASES where innervating constitutional treatment is applied, and tonic treatment is desirable, this preparation will be found to act with safety and satisfaction.

IST ACTION IS PROMPT, stimulating the appetite, and the digestion, it promotes assimilation, and enters directly into the circulation with the food products.

THE PRESCRIBED DOSE produces a feeling of buoyancy, removing depression or melancholy, and hence is of great value in the treatment of **mental and nervous affections.**

From its exerting a double tonic effect and influencing a healthy flow of the secretions, its use is indicated in a wide range of diseases.

Each Bottle of Fellow's Hypophosphites contains 128 doses.

Prepared by JAMES I. FELLOWS, Chemist,

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Circulars and Samples sent to Physicians on appliction.

☞SPECIAL TO PHYSICIANS.—ONE large bottle containing 15 oz. (which usually sells for $1.50) will be sent upon receipt of **Fifty Cents** with the application, this will be applied to the prepayment of Expressage, and will afford an opportunity for a thorough test in Chronic cases of Debility and Nervousness. Express charges prepaid upon all samples.

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Standard pharmacetical preparations of the United States and foreign Phaemacopœias, and non-officicial preparations of large variety. Of the latter class we make a specialty of Fluid Extracts prepared from new and rare drugs from various parts of the world.

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Coca Leaves.
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Eucalyptus Globulous.
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Ginger, Mexican.
Grindelia Robusta.
Griedelia Squarroea.
Guaco Leaves.
Guarana.
Helianthella.
Honduras Bark.
Horsemint.
Iron Wood.
Jaborandi.
Jamaica Dogwood.
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Judas Tree.
Juriballi.
Kamala.
Kava Kava.
Kooso Flowers.
Lilly of the Valley Flws.
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Manaca.
Mango Bark.
Mango Fruit.
Manzanita Leaves.
Mercury Weed.
Mistletoe.
Musk Root.
Paraguay Tea.
Pulsatilla.
Quebracho Bark.
Quinine Flowers
Rhus Aromatica.
Sabbatia Campestris.
Sandal Wood.
Sarracenia Flava.
Sassy Bark.
Saw Palmetto.
Shepherd's Purse.
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Stylosanthes.
Sundew.
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Tomato.
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Urechites Suberecta.
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Yerba Buena.
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Zoapatle.

SUGAR COATED PILLS.

Our list of Sugar Coated Pills of the United and British Pharmacopœias, comprises most of the officinal and popular formulæ known to the profession, to which we have added several new and valuable combinations. Our pills are made entirely by hand, from the purest materials, and are sugar and gelatine coated by the latest and most approved processes. For solubility, regularity of shape, and beauty of finish, they are excelled by none.

IMPORTANT.—Our pills being coated while the mass is yet soft, will remain so for years. To be convinced of their extraordinary solubility, it is only necessary to open a few of them, for instance, quinine, chinchodia, or blue pills, all of which are usually found in the market, hard and insoluble. note also the rapidity with which the coating is dissolved in the saliva.

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One of the greatest improvements of modern pharmacy is the use of Gelatine in various forms to render medicines more sightly, and to disguige their nauseous taste. This has given origin to the Gelitine Coated Pill—a full line of which, of similar formulæ to our sugar coated pills, will be found on our list—and also to the Hard, and the Soft Gelatine Capsules. We are dispensing Hard Capsules, empty and filled. The Soft, Elastic Capsules, however, are from the nature of their formation, always filled before leaving our laboratory. These Capsules are so soft and elastic that their walls may be brought into juxtaposition, and yet they will regain their original shape and size when the pressure is removed. This property renders them very easy of deglutioion, and they will slip down like an oyster or the yelk of an egg, though the largest of them is about half the capacity of a fluidounce.

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Solution of Sicerolc Acid.
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Sanguis Bovinus Exsiccatus.
Liquor Acidi Phosphorici.
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Soluble Elastic Capsules.
Goa Powder.
Crude Petroleum Mass.
Chian Turpentine.
Concentrated Ext. Witch Hazel.
Morure or Mercurio Vegetal.
Sugar Test Flasks.
Empty Gelatine Capsules.
Liquor Egotæ Purificatus.
Chlor-Anodyne.
Tonga.
Hoang-Nan.
Menhol.
Chaulmoogra Oil.
Gurjun Balsam.